

Simulation Learning System—Medical-Surgical Implementation Guide

prepared by

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Maryland Heights, Missouri 63043

SIMULATION LEARNING SYSTEM—MEDICAL--SURGICAL
IMPLEMENTATION GUIDE
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ISBN: 978-1-4377-2629-9

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ISBN: 978-1-4377-2629-9

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Printed in the United States of America

Last digit is the print number: 9 8 7 6 5 4 3 2 1

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Introduction

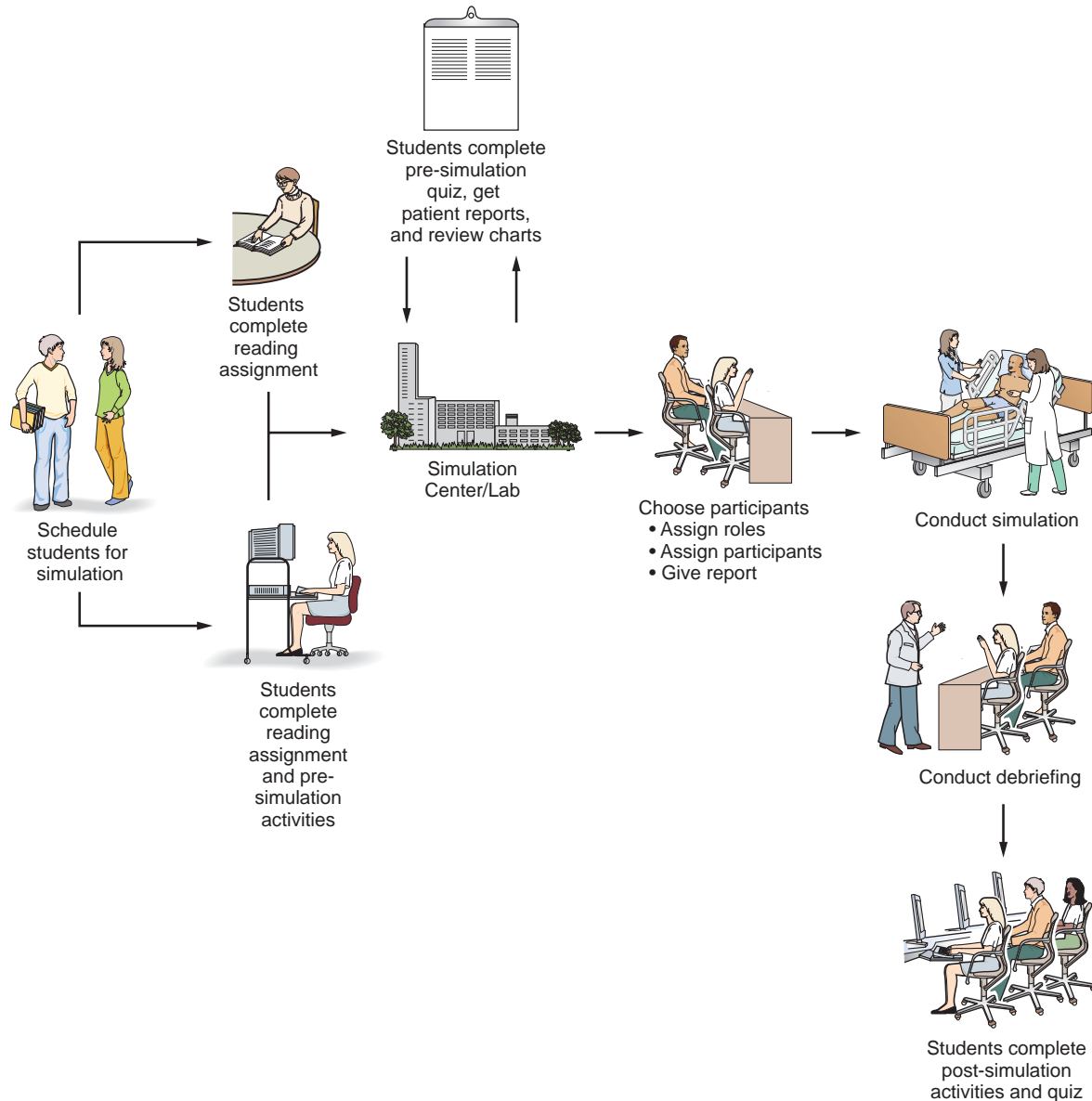
In today's health care climate, nurse educators are faced with the ever-increasing challenge of providing optimal clinical experiences for their students that truly reflect the realities of increased patient acuity, the nursing shortage, and the changing nature of the clinical unit. As a means of addressing these issues, clinical simulation has become an important component of nursing curricula. Human patient simulators can respond physiologically to disease, trauma, and care—very much like actual human beings would respond. Recent advances in technology have greatly enhanced the capability of human patient simulators to replicate the types of situations that students are likely to encounter in clinical practice.

Clinical simulation provides a controlled environment in which students can practice the nursing process and sharpen their critical thinking and decision-making skills before caring for real patients in the clinical setting. During clinical simulation, nursing students experience a realistic patient problem and use the nursing process to guide their interactions with the human patient simulator. Students collect and analyze assessment data and intervene based on their understanding of the patient situation. The human patient simulator is controlled by the simulation instructor (hereafter referred to as the facilitator) to respond to student interventions, whether they are appropriate or inappropriate. The human patient simulator can subsequently recover from the problem, worsen, or even die from a lack of intervention or as a result of an inappropriate intervention.

When using clinical simulation, instructors may need to remind students to suspend disbelief and immerse themselves in the experience. Students should interact with simulated patients as they would with live patients, asking questions and responding to all participants. They should be encouraged to talk and think “out loud” as they progress through the scenario. Simulation provides a safe environment in which to practice clinical decision-making skills without risking the health of real patients. The clinical simulation environment provides opportunities to practice not only skills related to the nursing process, but also skills of communication, delegation, and patient and family education.

Following the completion of the clinical simulation scenario, debriefing is conducted by the facilitator to provide students with the opportunity for self-reflection and to give students immediate feedback regarding their actions during the scenario. The debriefing phase is integral to the learning process; this structured reflection process helps students find relevance and meaning in the simulation experience.

Clinical simulation provides endless learning opportunities and can be used to reinforce understanding of difficult concepts and to allow students to practice skills and techniques related to communication, teamwork, and delegation. The Simulation Learning System (SLS) is an educationally sound program that provides extensive step-by-step instruction for integrating simulation into the nursing curriculum and features a comprehensive set of resources to assist both nursing educators and students. Developed, reviewed, and tested by nationally recognized simulation and nursing education experts, the SLS protocol emphasizes the teaching and learning possibilities of clinical simulation. By following this process, students and instructors alike can gain the maximum benefits of the simulation experience.






The SLS contains a library of clinical simulation scenarios featuring patients with a variety of conditions. Each scenario is accompanied by a complete electronic medical record. The clinical simulation experience begins with pre-simulation activities that prepare the student to enter the simulation laboratory; progresses to the simulation experience as the student provides care for the patient; and concludes with debriefing and post-simulation activities designed to promote reflection and deeper understanding. The pre- and post-simulation exercises, quizzes, and multimedia resources are designed to enhance learning outcomes and assist the facilitator in student evaluation.

The SLS contains a wide array of resources. As you learn about the vast opportunities of this product, you will find that most of the work of running a simulation has been done for you. Before heading to the simulation lab or selecting a scenario to run with your students, take some time to familiarize yourself with the resources, tools, and guidelines of the SLS. Descriptions of each of these resources can be found in this guide.










The SLS Home Page

All SLS program data can be accessed via the *Evolve* online course portal. *Evolve* is the gateway to your textbook-specific simulation product. Simply select the SLS for your adopted textbook and you are on your way.

The SLS Home Page on *Evolve* contains links to all of the SLS materials. Once you are on the Home Page for the SLS, don't let the simplicity of the presentation fool you. Behind each click is an extensive set of resources for running successful simulations.

- The *Implementation Guide* is this document.
- The folder  named *Simulation Scenarios* contains an expandable list of scenarios.
- The *EMR User Guide* provides comprehensive instructions for the SLS Electronic Medical Record for both faculty and student use.
- The *Scenario Index* lists each scenario that is currently available. This grid will continue to expand as new scenarios become available.
- The *Skills Drills Library*  contains a library of modules, each focused on the demonstration of a single skill. Each skills drills module includes set-up instructions for the instructor, a mini-scenario challenge with a corresponding EMR, a performance checklist, and a multimedia demonstration.
- The *Simulation Center Resources* consist of select sites for purchasing equipment, locating resources to set up your lab, finding support organizations, and more. This list will continue to be updated as new sources are identified.
- The *Feedback* folder  provides two ways to submit your comments and recommendations.
 - The *Request a Scenario* link gives you the opportunity to inform us of any specific scenarios that may enhance your particular curriculum. The suggestions will be routinely reviewed and will help us continue to develop timely and relevant scenarios.
 - The *Provide Feedback* link lets you send comments and questions directly to the SLS development team.
- The *Acknowledgements* link contains a list of the fantastic nursing and health care professionals who have worked to develop the SLS.
- The *Course Updates* link contains updates made to the SLS.



-  [Implementation Guide](#)
-  [Simulation Scenarios](#)
-  [EMR User Guide](#)
-  [Scenario Index](#)
-  [Skills Drills Library](#)
-  [Simulation Center Resources](#)
-  [Feedback](#)
Send us your comments and recommendations for the SLS.
-  [Acknowledgements](#)
-  [Course Updates](#)

The SLS provides you with comprehensive resources to support your simulation mission, all of which are fully integrated with your adopted textbook. Each simulation scenario has been uniquely tagged to page-specific content within the textbook. As you work through the exercises, assignments, and scenarios, you will find text references providing rationales and related content.

In the next section, we will walk through the SLS product step-by-step. Please take the time to understand each step so that when you begin to run a scenario, you will have a complete grasp of the resources available to you.

Let's get started.

Simulation Learning System Recommended Protocol

The following is the recommended protocol for facilitating a simulation scenario from start to finish using the SLS. This protocol includes a variety of options for instructors to customize the simulation experience to meet the unique needs of their students. Individual steps of the protocol may be modified as desired to maximize the use of the SLS in your academic setting.

1. Instructor selects the appropriate simulation scenario using the *Scenario Index* and prepares for simulation using the *Implementation Module*.
2. Instructor schedules students for simulation.
3. Instructor activates student *Evolve* access to pre-simulation activities as desired: **Reading Assignment, Concept Mapping, Pre-simulation Exercise, Pre-simulation Quiz, Skills Drills, Patient Report, and Electronic Medical Record**.
4. Students access *Evolve* to complete the assigned pre-simulation activities.
5. Instructor prepares the simulation environment using the *Facilitator's Packet*.
6. Students arrive at the simulation lab.
7. Instructor orients students to simulation environment.
8. Instructor assigns roles and distributes the **Participant Role Badges, Additional Participant Response Guide(s), and Observer Evaluation Rubric**.
9. Instructor or student provides **Patient Report** in written or verbal form to all participants.
10. Instructor signals start of scenario and students engage in simulation.
11. Students reference the *Electronic Medical Record* during the scenario to obtain patient care information, such as orders and patient data.
12. Instructor progresses scenario using the **Algorithm Quick Card**.
13. Instructor uses the **Patient Response Guide** to act as patient.
14. Instructor evaluates student performance using the **Performance Checklist**.
15. Non-participating students evaluate student performance using the **Observer Evaluation Rubric**.
16. Students document care during and after the scenario using the *Electronic Medical Record*.
17. Instructor signals end of scenario.
18. Instructor leads scenario debriefing and guided discussion using the **Debriefing Procedure, Debriefing/Reflection Guide, and Guided Discussion** material.
19. Instructor activates student *Evolve* access to post-simulation activities as desired: **Electronic Medical Record, Care Plan Constructor, Journaling, Interdisciplinary Communication, Post-simulation Exercise, and Post-simulation Quiz**.
20. Students access *Evolve* to complete the assigned post-simulation activities.
21. Instructor evaluates student work in the *Evolve* gradebook and communicates feedback to students.



SLS Skills Drills

SLS Skills Drills is a new feature added to the SLS to provide an opportunity for students to practice discrete skills outside of the multifaceted context of an SLS scenario. **Skills Drills** are designed so that they can be set-up by the instructor or learning laboratory personnel for students to complete with or without supervision. These mini-scenarios focus on the application of a single skill within the context of a patient situation. The patient context for each drill encourages basic critical thinking, rather than the simple memorization of skill steps. In addition, several variations of each skill are provided, facilitating skill procedure discernment.

In addition to helping prepare students for an SLS scenario, **Skills Drills** may be used for:

- Student practice after initial skill instruction
- Student self-testing prior to instructor-mediated skill testing
- Student skill practice prior to a clinical experience
- Student remediation
- Competency testing of student skill performance

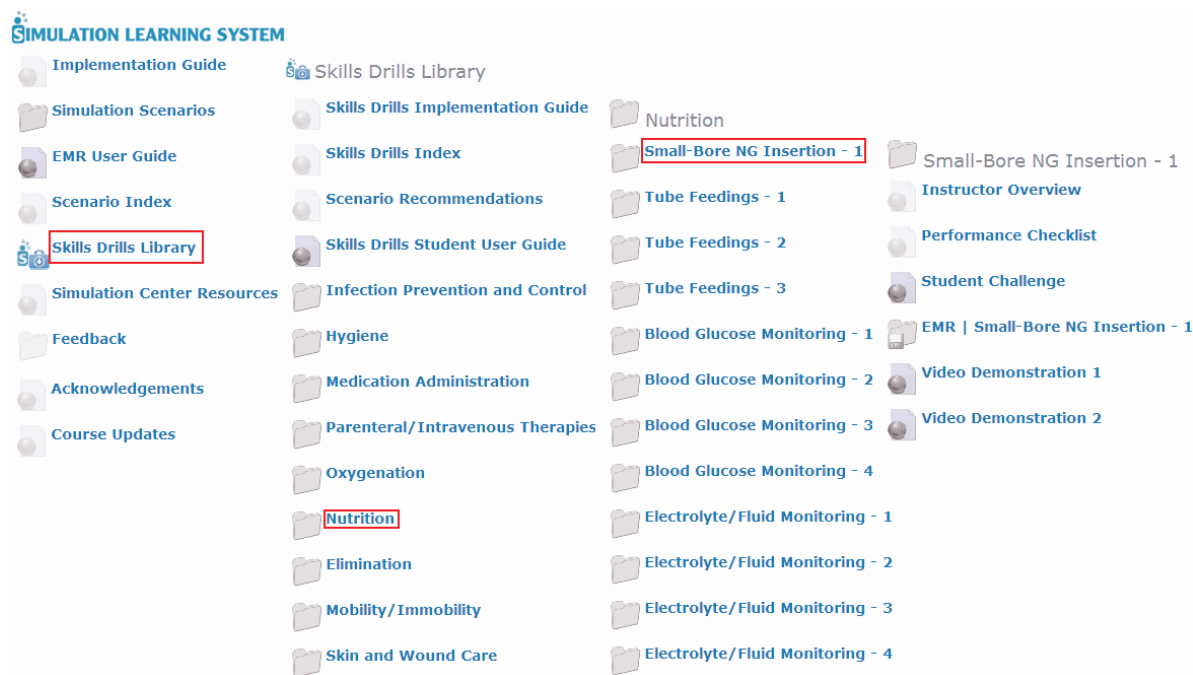
The **Skills Drills** folder contains an entire library of drills appropriate for the medical-surgical SLS course. Some of the drills are geared specifically to SLS scenarios, while others are meant for general skills practice. The medical-surgical **Skills Drills** library contains over 150 independent skills drills.

SLS SKILLS DRILLS RECOMMENDED PROTOCOL

The following is the recommended protocol for integrating **Skills Drills** into the SLS experience. This protocol provides the steps for implementing **Skills Drills** as preparation for an SLS scenario. Individual steps of the protocol may be modified as desired to maximize the use of **Skills Drills** in your academic setting.

1. Instructor views the **Skills Drills** recommendations from the menu of the selected SLS scenario.
2. Instructor reviews the **Skills Drills** library and assigns any of the recommended **Skills Drills** as preparation for the selected SLS scenario. Additional **Skills Drills** from the library can be assigned as desired.
3. Students access Evolve to view the **Student Challenge**, including reading assignment, the **Electronic Medical Record**, and a **Video Demonstration**.
4. Instructor prepares the skills lab environment following the staging instructions within the **Instructor Overview**.
5. Students arrive at the **Skills Drills** lab.
6. Students review the **Student Challenge** and **Electronic Medical Record** and complete the drill challenge.
7. Students reference the **Electronic Medical Record** during the drill to obtain patient care information, such as orders and previous assessments.
8. Students record care provided in the **Electronic Medical Record**.
9. Evaluation observer completes the **Performance Checklist** as desired.

ACCESSING SKILLS DRILLS



As seen in the above set of screen shots, the *Skills Drills* library is accessed from the SLS Home Page. Inside, the library is organized by core topic areas. Within each of the topic folders is a list of available *Skills Drills*. A uniform set of resources is available within each drill folder.

Infection Prevention and Control

Hand Hygiene

Hygiene

Oral Hygiene
Care of Sensory Aids
Postmortem Care

Medication Administration

Medication Calculations
Oral Medications
Injections
Various Meds/Routes
IV Fluid Containers
IV Bolus
Various IV Routes
Peripheral IV
Central Venous Devices

Parenteral/Intravenous Therapies

Initiating IV Therapy
Regulating IV Flow Rate
IV Maintenance
IV Dressing Change
Central Venous Access Devices
Blood Product Administration

Oxygenation

Suctioning
Artificial Airway
Chest Tubes
Oxygen Administration
Resuscitation
Oxygenation Evaluation via ABGs
Ventilator Management

Nutrition

Small-Bore NG Insertion
 Tube Feedings
 Blood Glucose Monitoring
 Electrolyte/Fluid Monitoring
 Parenteral Nutrition

Elimination

Indwelling Catheter Care
 Ostomy Pouching
 Peritoneal Dialysis
 Hemodialysis Shunt Care

Mobility/Immobility

Transfer Techniques
 Traction and Casting

Skin and Wound Care

Treating Pressure Ulcers
 Wound Irrigation
 Dressing Change

SKILLS DRILLS – STUDENT VIEW

For each drill, students have access to a **Student Challenge**, an **Electronic Medical Record (EMR)**, and a **Video Demonstration**.



The **Student Challenge** includes a brief summary of the patient situation, a reading assignment, and a specific skill-related challenge. Each drill revolves around a simulated patient and the patient's **EMR**. The current day and time info serves as a grounding point and corresponds to the **EMR** data. A specific patient situation or order drives each challenge.

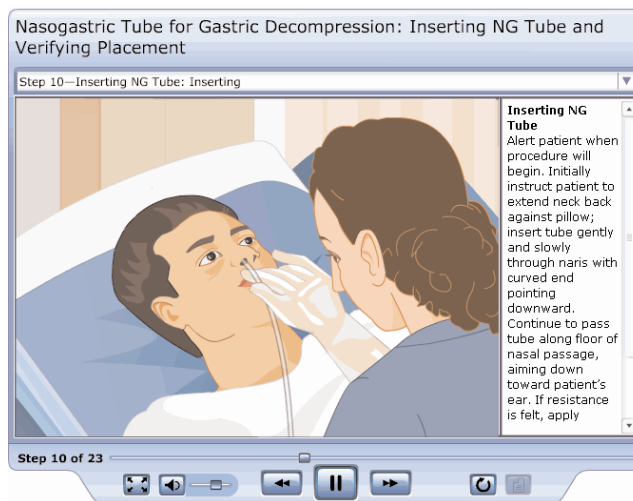
Drill: Small-Bore NG Insertion—1	
Scenario Challenge	Preparation
<p>Ann Tran is a 16-year-old female who has been admitted for treatment of malnutrition secondary to anorexia nervosa. Her provider has ordered a small-bore NG-tube to be inserted to supplement her nutritional intake. Verify the order and perform the intervention. Document your care in the EMR.</p> <p>Current day & time: Tuesday 1130</p>	<p>Readings: Perry & Potter <i>Clinical Nursing Skills and Techniques</i>, 7th Edition pp. 829-837</p> <p>Elkin, Perry, & Potter <i>Nursing Interventions & Clinical Skills</i>, 4th Edition pp. 705-713</p>

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The **EMR** is an integral element of each skills drill. While students can review the record before arrival to the lab, access to the **EMR** within the lab setting is essential for successful completion of the drill challenge. Most **Skills Drills** direct students to review the **EMR** prior to initiating the challenge. Students will need to review vital patient information, such as prior assessment findings, medication administration history, and provider orders. Students also need **EMR** access in order to document their care. As with the SLS scenarios, all information recorded by the student during the skills drill can be submitted for instructor review. See the **EMR User Guide** for more information.








The screenshot shows the SLS EMR interface. At the top, it says 'SIMULATION LEARNING SYSTEM' with links for Save, Download, Submit, Restart, and Log off. Below this is a header bar with patient information: HRN: 2963331, Room: 811, Age: 16, Provider: Susan Rogers, MD, Code Status: Full code. The main content area is divided into two sections. On the left is a sidebar menu with options: Identification, Flow Sheets, Medication Records, Nurses' Notes, Orders, Physician's Progress Notes, Laboratory Reports, Patient Education, and Signatures. The right section is titled 'Identification' and contains a circular logo with 'SLS' and 'SKILLS DRILLS' text. To the right of the logo is a table of patient information: HRN: 2963331, Patient Name: Ann Tran, Room: 811, Gender: Female, Age: 16, Provider Name: Susan Rogers, MD, Primary Diagnosis: Anorexia nervosa, Secondary Diagnosis: (blank), Allergies: No known allergies, Height: 5 ft 4 in, Weight (at admission): 92 lb, Code Status: Full code. At the bottom, it says 'User: Danny Witzofsky (witzofsky) | Scenario Tran | Sim Day/Time: Tue at 11:30' and '© Elsevier. All rights reserved.'

For most **Skills Drills**, a **Video Demonstration** of the related skill is available for student review. These demonstrations are meant to serve as basic visual guides to the related skill. For the step-by-step skill process, students should refer to the textbook reading assignments included in the challenge.



SKILLS DRILLS – INSTRUCTOR VIEW

In addition to the student resources, instructors have access to an **Instructor Overview** and **Performance Checklist** for each skills drill.

-  Small-Bore NG Insertion - 1
 -  **Instructor Overview**
 -  **Performance Checklist**
 -  **Student Challenge**
 -  **EMR | Small-Bore NG Insertion - 1**
 -  **Video Demonstration 1**
 -  **Video Demonstration 2**

The **Instructor Overview** contains the same information as the **Student Challenge**, along with the purpose of the drill, a list of expected student outcomes, and a complete set of staging instructions.



Drill: Small-Bore NG Insertion—1

Category: Nutrition

Skill: Small-bore NG insertion
Variation: Teenager, anorexic

Scenario	Student Outcomes
<p>Student instructions: Ann Tran is a 16-year-old female who has been admitted for treatment of malnutrition secondary to anorexia nervosa. Her provider has ordered a small-bore NG-tube to be inserted to supplement her nutritional intake. Verify the order and perform the intervention. Document your care in the EMR.</p> <p>Current day & time: Tuesday 1130</p> <p>Readings: Perry & Potter <i>Clinical Nursing Skills and Techniques</i>, 7th Edition pp. 829-837</p> <p>Elkin, Perry, & Potter <i>Nursing Interventions & Clinical Skills</i>, 4th Edition pp. 705-713</p>	<p>Purpose: To provide students with the opportunity to practice inserting an NG-tube.</p> <p>Student outcomes:</p> <ol style="list-style-type: none"> 1. Verifies provider order in the EMR. 2. Reviews patient's medical history for nasal problems (e.g., nosebleeds, oral facial surgery, facial trauma, past history of aspiration, or anticoagulation therapy). 3. Gathers supplies. 4. Performs hand hygiene. 5. Identifies patient using 2 identifiers. 6. Introduces self and explains procedure. 7. Assesses patency of nares. 8. Stands on same side of bed as nares for insertion and assists patient to high-Fowler's position (unless contraindicated). 9. Places bath towel over chest and keeps facial tissue within reach. 10. Determines length of tube to be inserted by: <ul style="list-style-type: none"> • Measuring distance from tip of nose to earlobe to xiphoid process of sternum • Marking measurement with tape

When preparing the lab from the staging instructions, either the simple set-up or complete set-up can be used. The simple set-up includes only the props and equipment needed for the completion of the specific skill challenge. The complete set-up includes all the props and equipment needed to create the full patient situation. The complete set-up can be used for a richer simulation experience.

Drill: Small-Bore NG Insertion—1

Staging Instructions	
<p>Simple set-up:</p> <ul style="list-style-type: none"> • Manikin (female) capable of NG-tube insertion with reservoir of liquid • Simulating gastric contents • Patient identity band • EMR for Ann Tran • Clock sign set to 1130 • Clean gloves in a variety of sizes • Hand sanitizer • Paper towels • Over-bed table • Penlight • pH indicator strips • Straw • Tape • Tongue blades • Towels • Suction catheter • Suction connection tubing • Wall suction • NG-tube fixation devices • NG-tube: 8-to 12-French with guide wire or stylet • Syringes, 60 mL with Luer-Lok or catheter-tip • Tincture of benzoin or other skin adhesive <p>Facilitator instructions: Place manikin sitting upright in bed.</p>	<p>Complete set-up: Items in simple set-up plus . . .</p> <ul style="list-style-type: none"> • Drinking cup • Over-bed table • Water pitcher • IV pole • IV pump • Peripheral IV: 22-gauge angiocatheter to right hand • IV solution: Dextrose 5% in lactated Ringer's infusing at 100 mL/hr

The **Performance Checklist** is comprised of the student outcome list in an easy-to-use evaluation-gauged table. A printed copy of the **Performance Checklist** should be made available for the designated evaluation observer (instructor or peer). The checklist can also be made available for student self-evaluation.

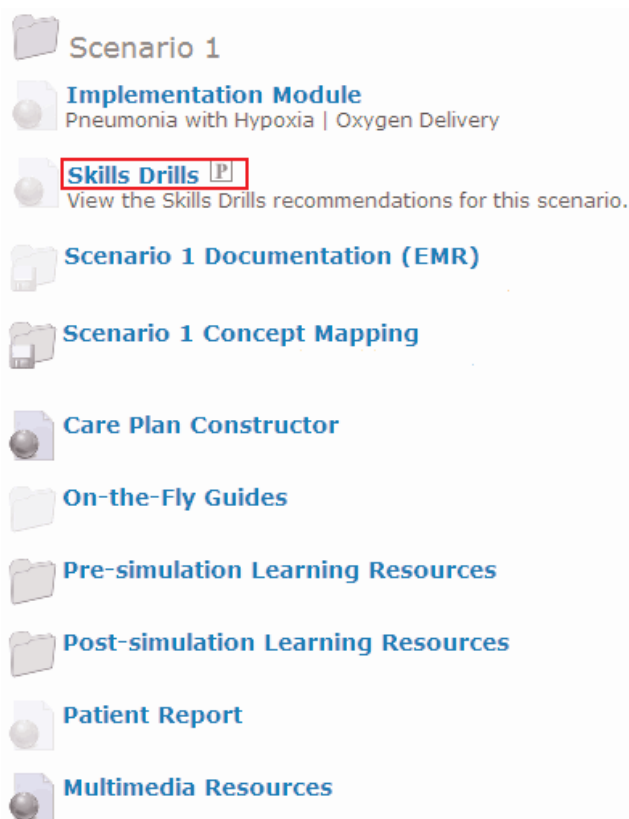


Drill: Small-Bore NG Insertion—1

Evaluation Rating			Student Outcomes	Comments
Exceeds Expectations	Meets Expectations	Does Not Meet Expectations		
			Verifies provider order in the EMR.	
			Reviews patient's medical history for nasal problems (e.g., nosebleeds, oral facial surgery, facial trauma, past history of aspiration, or anticoagulation therapy).	
			Gathers supplies.	
			Performs hand hygiene.	
			Identifies patient using 2 identifiers.	
			Introduces self and explains procedure.	
			Assesses patency of nares.	
			Stands on same side of bed as nares for insertion and assists patient to high-Fowler's position (unless contraindicated).	

ASSIGNING SKILLS DRILLS

When assigning drills for the preparation of an SLS scenario, the first step is to review the **Skills Drills** recommendations from within the scenario documents. From the scenario menu, click on the **Skills Drills** link. This will pull up a list of the **Skills Drills** recommendations for the scenario. This list can also be accessed through several links within the **Implementation Module**.



Access the **Skills Drills** library from the SLS Home Page (see page 3) to review the details of recommended drills. While the recommendations provided for each scenario consist of the skill variations that most closely relate to the specific variation of each skill encountered in the scenario, additional variations from the library can also be assigned as desired. Students have access to the full **Skills Drills** library, so no action within the *Evolve* learning management system is required when assigning drills.

Scenario 1 Skills Drills Recommendations







The following SLS Skills Drills are recommended for students in preparation of Scenario 1. They can be accessed through the Skills Drills library found on the SLS Home Page. These recommendations consist of the variations that most closely relate to the specific variation of each skill found in the scenario. While instructors may, at times, find it useful to limit the Skills Drills assigned with a scenario to the list provided, assigning several of the additional skill variations included in the library may be desired for the development of skill discernment and mastery.





Category	Skill	Variation
Vital Signs	Temperature—2	Tympanic
Vital Signs	Temperature—3	Temporal
Vital Signs	Respirations—3	Rales/Rhonchi, Diminished
Vital Signs	Oxygen Saturation—2	Abnormal Finding
Medication Administration	Medication Calculations—1	Calculate to Age/Weight
Medication Administration	Medication Calculations—2	Calculate to Weight
Medication Administration	Medication Calculations—11	Liquid Suspension
Medication Administration	Oral Medications—2	Liquid
Medication Administration	Oral Medications—4	Tablet via G-Tube
Medication Administration	Oral Medications—5	Liquid via G-Tube
Nutrition	Tube Feedings—1	NG-Tube, Intermittent
Nutrition	Tube Feedings—2	G-Tube, Intermittent
Elimination	Gastrointestinal Aspiration for pH Measurement—1	Normal Result
Skin and Wound Care	Dressing Change—1	Simple, Dry Gauze to Laceration
Skin and Wound Care	Dressing Change—2	Dry, Non-Stick Dressing to Abdomen





Scenario Index

Use the **Scenario Index** to review the scenario, diagnoses, primary challenge, and skills to identify the scenario best suited to the level of your students and your teaching needs.





The **Scenario Index** may be accessed from the SLS Home Page. The index provides the best overview descriptions of the scenarios.





Scenario	Patient Data Est. Scenario Time* Est. Debriefing Time*	Scenario Skills	Scenario Presentation and Diagnoses	Primary Simulation Challenge
RESPIRATORY				
MS-01 Basic 	Patricia Newman 61-year-old Female Scenario: 20-30 minutes Debriefing: 20-30 minutes Pneumonia with Hypoxia Oxygen Delivery	<ul style="list-style-type: none"> Conduct assessment Recognize hypoxia Recognize elevated temperature Troubleshoot disconnected oxygen tubing Administer oxygen via nasal cannula Administer acetaminophen per PRN order Provide patient education and support Access and document care in EMR 	Patient with pneumonia experiences hypoxia when oxygen via nasal cannula is inadvertently discontinued after patient transfer. Primary diagnosis: Pneumonia Secondary diagnosis: Emphysema	Learner assesses and manages care for a patient experiencing hypoxia by troubleshooting disconnected oxygen tubing.
MS-02 Advanced 	Patricia Newman 61-year-old Female Scenario: 20-30 minutes Debriefing: 20-30 minutes Pneumonia with Acute Respiratory Distress Oxygen Delivery	<ul style="list-style-type: none"> Conduct assessment Recognize respiratory distress Administer oxygen via face mask Notify provider of status change Draw or coordinate sample collection for arterial blood gases Coordinate chest x-ray Provide emotional support and education Access and document care in EMR 	Patient with pneumonia develops respiratory distress. Primary diagnosis: Pneumonia Secondary diagnosis: Emphysema	Learner assesses and manages care for a patient experiencing respiratory distress.
MS-03 Basic 	Jacqueline Catanazaro 45-year-old Female Scenario: 20-30 minutes Debriefing: 20-30 minutes Asthma Exacerbation Acute Management	<ul style="list-style-type: none"> Conduct assessment Recognize asthma exacerbation Administer oxygen via non-rebreather mask Notify provider Start IV and IV fluids Collect blood specimens Administer nebulizer treatment Provide patient education and support Access and document care in EMR 	Patient with asthma exacerbation and difficulty breathing presents to emergency department. Primary diagnosis: Asthma Secondary diagnosis: Schizophrenia	Learner conducts initial patient assessment and manages care in emergency department for a patient experiencing an asthma exacerbation.
MS-04 Advanced 	Jacqueline Catanazaro 45-year-old Female Scenario: 20-30 minutes Debriefing: 20-30 minutes Asthma Exacerbation & Anxiety Communication & Oxygen Delivery	<ul style="list-style-type: none"> Conduct assessment Recognize anxiety and mild respiratory distress Use therapeutic communication to calm and reassure patient Administer oxygen via BiPAP as ordered Recognize IV infusing at incorrect rate Adjust IV to ordered rate Notify provider of status change Provide patient education and support Access and document care in EMR 	Patient admitted with asthma exacerbation experiences increased anxiety and mild respiratory distress. Primary diagnosis: Asthma Secondary diagnosis: Schizophrenia	Learner assesses and manages care for an anxious patient experiencing mild respiratory distress.





Scenario	Patient Data Est. Scenario Time* Est. Debriefing Time*	Scenario Skills	Scenario Presentation and Diagnoses	Primary Simulation Challenge
MS-05 Basic 	Pablo Rodriguez 71-year-old Male Scenario: 20-25 minutes Debriefing: 20-25 minutes Lung Cancer Nausea & Hypokalemia	<ul style="list-style-type: none"> Conduct assessment Recognize nausea Recognize hypokalemia Notify provider with status update Administer IV antiemetic per PRN order Change IV fluid per order Administer IV potassium per order Provide patient education and support Access and document care in EMR 	Patient admitted for management of cancer-related nausea, vomiting, and pain experiences hypokalemia and ongoing nausea. Primary diagnosis: Non-small cell pulmonary carcinoma Secondary diagnosis: Secondary: Malnutrition, chronic pain, nausea and vomiting, constipation	Learner assesses and manages care for a patient experiencing nausea and hypokalemia.
MS-06 Advanced 	Pablo Rodriguez 71-year-old Male Scenario: 15-20 minutes Debriefing: 15-20 minutes Lung Cancer Narcotic Overdose	<ul style="list-style-type: none"> Conduct assessment Recognize tachypnea and oversedation Stop PCA infusion Activate emergency response Notify provider Administer IV naloxone per order Provide patient education and support Access and document care in EMR 	Patient admitted for management of cancer-related nausea, vomiting, and pain experiences oversedation secondary to narcotic administration. Primary diagnosis: Non-small cell pulmonary carcinoma Secondary diagnosis: Secondary: Malnutrition, chronic pain, nausea and vomiting, constipation	Learner assesses and manages care for a patient experiencing respiratory depression and oversedation.
MS-31 Basic 	Tom Handy 62-year-old Male Scenario: 15-20 minutes Debriefing: 15-20 minutes Lung Cancer Postoperative Pain & Hypoxia	<ul style="list-style-type: none"> Conduct assessment Recognize hypoxia and pain Recognize misplaced nasal cannula Reapply nasal cannula Administer IV morphine per PRN order Encourage postoperative breathing exercises Provide patient education and support Access and document care in EMR 	Patient admitted for lung lobectomy experiences hypoxia in postoperative period when his nasal cannula accidentally falls off. He also experiences pain, preventing postoperative breathing exercises. Primary diagnosis: Squamous cell carcinoma of the right lung Secondary diagnosis: Chronic bronchitis	Learner assesses and manages care for a postoperative patient with a chest tube experiencing hypoxia and pain.
MS-32 Advanced 	Tom Handy 62-year-old Male Scenario: 10-15 minutes Debriefing: 10-15 minutes Lung Cancer Acute Tension Pneumothorax	<ul style="list-style-type: none"> Conduct assessment Recognize signs and symptoms of pneumothorax Clear chest tubing obstruction Increase oxygen flow rate Provide patient education and support Access and document care in EMR 	Patient admitted for lung lobectomy experiences acute tension pneumothorax when his chest tube tubing becomes fully obstructed under side rail of bed after transfer. Primary diagnosis: Squamous cell carcinoma of the right lung Secondary diagnosis: Chronic bronchitis	Learner assesses and manages care for a postoperative patient with a chest tube and an acute tension pneumothorax.





Scenario	Patient Data Est. Scenario Time* Est. Debriefing Time*	Scenario Skills	Scenario Presentation and Diagnoses	Primary Simulation Challenge
CARDIOVASCULAR				
MS-07 Advanced 	Carmen Gonzales 56-year-old Female Scenario: 15-20 minutes Debriefing: 15-20 minutes Heart Failure, Diabetes, & Osteomyelitis Fluid Overload & Hyperglycemia	<ul style="list-style-type: none"> Conduct assessment Recognize fluid volume overload and hyperglycemia. Elevate head of bed Titrate oxygen Notify provider Administer IV furosemide per order Administer SQ insulin per order Decrease rate of IV fluid per order Provide patient education and support Access and document care in EMR 	Patient admitted for wound debridement of gangrenous leg experiences postoperative fluid volume overload and hyperglycemia. Primary diagnosis: Osteomyelitis and gangrene of left leg Secondary diagnosis: Diabetes mellitus type 2, coronary artery disease, heart failure, hypertension	Learner assesses and manages care for a postoperative patient experiencing fluid volume overload and hyperglycemia.
MS-08 Basic 	Delores Gallegos 82-year-old Female Scenario: 15-20 minutes Debriefing: 15-20 minutes Heart Failure Digoxin Toxicity & Hypokalemia	<ul style="list-style-type: none"> Conduct assessment Recognize digoxin toxicity, hypokalemia, and hypotension Notify provider Hold digoxin and metoprolol Administer PO potassium Provide patient education and support Access and document care in EMR 	Patient admitted to skilled nursing facility experiences digoxin toxicity, hypokalemia, and hypotension. Primary diagnosis: Heart failure Secondary diagnosis: Atrial fibrillation	Learner assesses and manages care for patient in skilled nursing facility experiencing digoxin toxicity, hypokalemia, and hypotension.
MS-09 Basic 	Julia Parker 51-year-old Female Scenario: 20-25 minutes Debriefing: 20-25 minutes Myocardial Infarction Management of Stable Patient	<ul style="list-style-type: none"> Conduct assessment Recognize chest pain, hypertension, and anxiety as signs of evolving MI Titrate oxygen Calm patient to reduce oxygen demand Notify provider of status change Administer IV metoprolol per order Administer SL nitroglycerin per PRN order Decreasing IV fluid rate per order Coordinate ECG and blood work Provide patient education and support Access and document care in EMR 	Patient admitted to inpatient unit with suspected myocardial infarction experiences hypertension and chest pain. Patient remains stable. Primary diagnosis: Rule out myocardial infarction Secondary diagnosis: Diabetes mellitus, hypertension, hyperlipidemia	Learner assesses and manages care for a patient with a suspected myocardial infarction experiencing chest pain and hypertension.
MS-10 Advanced 	Julia Parker 51-year-old Female Scenario: 20-25 minutes Debriefing: 20-25 minutes Myocardial Infarction Management of Unstable Patient	<ul style="list-style-type: none"> Conduct assessment Recognize chest and back pain, nausea, hypertension, and premature ventricular contractions (PVCs) as signs of evolving MI Titrate oxygen Calm patient to reduce oxygen demand Notify provider of status change Administer IV morphine per PRN order Begin IV nitroglycerin infusion Coordinate ECG and blood work Provide patient education and support Access and document care in EMR 	Patient admitted to inpatient unit with suspected myocardial infarction experiences chest and back pain, nausea, hypertension, and PVCs. Patient becomes unstable if morphine and nitroglycerin are not administered. Primary diagnosis: Rule out myocardial infarction Secondary diagnosis: Diabetes mellitus, hypertension, hyperlipidemia	Learner assesses and manages care for a patient experiencing an evolving myocardial infarction.





14 SLS IMPLEMENTATION GUIDE FOR MEDICAL-SURGICAL NURSING





Scenario	Patient Data Est. Scenario Time* Est. Debriefing Time*	Scenario Skills	Scenario Presentation and Diagnoses	Primary Simulation Challenge
NEUROLOGICAL				
MS-11 Advanced 	Goro Oishi 66-year-old Male Scenario: 15-20 minutes Debriefing: 15-20 minutes Subarachnoid Hemorrhage Tracheostomy Suctioning	<ul style="list-style-type: none"> Conduct assessment Recognize need for tracheostomy suctioning Suction tracheostomy tube Perform tracheostomy care Provide family education and support Access and document care in EMR 	Patient admitted for subarachnoid hemorrhage with progressive neurological deterioration requires basic tracheostomy suctioning and care. Primary diagnosis: Subarachnoid hemorrhage Secondary diagnosis: Hypertension	Learner assesses and provides tracheostomy suctioning and care for unresponsive patient.
MS-12 Basic 	Goro Oishi 66-year-old Male Scenario: 15-20 minutes Debriefing: 15-20 minutes Subarachnoid Hemorrhage Bleed after Cerebral Arteriogram	<ul style="list-style-type: none"> Conduct post-procedure assessment Recognize bleed Apply pressure Notify provider Administer fluid bolus per order Provide family education and support Access and document care in EMR 	Patient admitted for subarachnoid hemorrhage returns from cerebral arteriogram and experiences hypotension and bleed from catheter puncture site. Primary diagnosis: Subarachnoid hemorrhage Secondary diagnosis: Hypertension	Learner conducts post-procedural assessment and identifies hypotension and bleed from catheter puncture site in unresponsive patient. Manages and coordinates care.
MS-13 Basic 	Andrea Wang 20-year-old Female Scenario: 15-20 minutes Debriefing: 15-20 minutes Spinal Cord Injury Postoperative Atelectasis	<ul style="list-style-type: none"> Conduct assessment Recognize pain, atelectasis, and patient's frustrations with injury Use therapeutic communication to allow patient to discuss frustrations Administer pain medication Assist patient with incentive spirometry and coughing and deep breathing exercises Provide patient education and support Access and document care in EMR 	Patient admitted for spinal fusion after spinal cord injury complains of pain and frustration about injury. She exhibits signs and symptoms of post-operative atelectasis. Primary diagnosis: T6 burst fracture Secondary diagnosis: Spinal fusion	Learner assesses and manages postoperative atelectasis in a patient with a spinal cord injury.
MS-14 Advanced 	Andrea Wang 20-year-old Female Scenario: 20-25 minutes Debriefing: 20-25 minutes Spinal Cord Injury Autonomic Dysreflexia	<ul style="list-style-type: none"> Conduct assessment Recognize autonomic dysreflexia Identify time of last catheterization as 8 hours ago Elevate head of bed Scan bladder Perform straight catheterization Provide patient education and support Access and document care in EMR 	Patient with impaired sensation experiences autonomic dysreflexia after not being catheterized for several hours. Primary diagnosis: T6 burst fracture Secondary diagnosis: Spinal fusion	Learner assesses and manages autonomic dysreflexia in a patient with a spinal cord injury.

Scenario	Patient Data Est. Scenario Time* Est. Debriefing Time*	Scenario Skills	Scenario Presentation and Diagnoses	Primary Simulation Challenge
MS-15 Basic 	James Franklin 67-year-old Male Scenario: 25-30 minutes Debriefing: 25-30 minutes Acute Ischemic Stroke Admission Assessment	<ul style="list-style-type: none"> Conduct initial nursing admission assessment including history and physical examination Provide patient and family education and support Access and document care in EMR 	Patient is stable and has just been admitted to the inpatient unit from the emergency department and requires a nursing admission assessment. Primary diagnosis: Right hemispheric acute ischemic stroke Secondary diagnosis: Hypertension	Learner conducts the initial nursing admission assessment for a patient experiencing acute ischemic stroke.
MS-16 Advanced 	James Franklin 67-year-old Male Scenario: 15-20 minutes Debriefing: 15-20 minutes Acute Ischemic Stroke rt-PA Administration	<ul style="list-style-type: none"> Conduct assessment Initiate rt-PA therapy per orders Provide patient and family education and support Access and document care in EMR 	Patient experiencing acute ischemic stroke is cleared for rt-PA administration and an order is provided to begin rt-PA administration. Primary diagnosis: Right hemispheric acute ischemic stroke Secondary diagnosis: Hypertension	Learner assesses patient and initiates rt-PA therapy per orders.
GASTROINTESTINAL/GENITOURINARY				
MS-17 Basic 	Piya Jordan 68-year-old Female Scenario: 15-20 minutes Debriefing: 15-20 minutes Abdominal Surgery Patient Controlled Analgesia	<ul style="list-style-type: none"> Conduct assessment Recognize normal vital signs and orientation Recognize complaints of pain Restart previously discontinued patient-controlled analgesia (PCA) Provide patient education and support Access and document care in EMR 	Potential narcotic overdose was suspected in postoperative patient by night nurse and PCA was stopped. Patient is now experiencing pain and requests PCA to be restarted. Primary diagnosis: Abdominal mass Secondary diagnosis: Chronic atrial fibrillation	Learner assesses and manages care for postoperative patient experiencing pain. Independently manages PCA administration within scope of practice.
MS-18 Advanced 	Piya Jordan 68-year-old Female Scenario: 15-20 minutes Debriefing: 15-20 minutes Abdominal Surgery Postoperative Fluid Volume Deficit	<ul style="list-style-type: none"> Conduct postoperative assessment Identify hypotension, tachycardia, and concentrated urine Notify provider Initiate IV fluid bolus per order Provide patient education and support Access and document care in EMR 	Patient experiences hypotension and fluid volume deficit in immediate postoperative period. Primary diagnosis: Abdominal mass Secondary diagnosis: Chronic atrial fibrillation	Learner assesses and manages care for a patient experiencing fluid volume deficit in immediate postoperative period.

Scenario	Patient Data Est. Scenario Time* Est. Debriefing Time*	Scenario Skills	Scenario Presentation and Diagnoses	Primary Simulation Challenge
MS-19 Advanced 	Delores Gallegos 82-year-old Female Scenario: 20-25 minutes Debriefing: 20-25 minutes Acute Renal Failure Hyperkalemia	<ul style="list-style-type: none"> Conduct assessment Recognize signs and symptoms of acute renal failure Notify provider of status change Administer IV furosemide Administer PO sodium polystyrene sulfonate Provide patient education and support Access and document care in EMR 	Patient in skilled nursing facility exhibits signs and symptoms of acute renal failure including confusion, decreased urine output, coarse lung sounds, and elevated serum BUN, creatinine, and potassium. Primary diagnosis: Heart failure Secondary diagnosis: Atrial fibrillation	Learner assesses and manages care for patient exhibiting signs and symptoms of acute renal failure.
MS-33 Basic 	Paul Jungerson 61-year-old Male Scenario: 20-25 minutes Debriefing: 20-25 minutes Colostomy Postanesthesia Confusion	<ul style="list-style-type: none"> Conduct assessment Recognize confusion, combativeness, and nasogastric tube pulled out by patient Ensure patient safety Use therapeutic communication to calm patient Notify provider of status change Administer IV lorazepam per order Reinsert nasogastric tube Provide patient education and support Access and document care in EMR 	Patient experiences postanesthesia confusion and combativeness and threatens his own safety and therapeutic regimen by pulling at tubes. Primary diagnosis: Colorectal cancer Secondary diagnosis: Colon resection with anastomosis	Learner assesses and manages care for a patient experiencing postanesthesia confusion and combativeness.
MS-34 Advanced 	Paul Jungerson 61-year-old Male Scenario: 20-25 minutes Debriefing: 20-25 minutes Colostomy Hyperkalemia Secondary to Medication Error	<ul style="list-style-type: none"> Conduct assessment Recognize hyperkalemia Identify incorrect IV fluid infusing Notify provider of situation and status Correct IV fluid per existing order Administer IV insulin and dextrose per order Coordinate ECG and blood work Provide patient education and support Access and document care in EMR 	Patient experiences hyperkalemia caused by an IV fluid error. Primary diagnosis: Colorectal cancer Secondary diagnosis: Colon resection with anastomosis	Learner assesses and manages care for a patient experiencing hyperkalemia caused by an IV fluid error.
ENDOCRINE				
MS-20 Basic 	Harry George 54-year-old Male Scenario: 20-30 minutes Debriefing: 20-30 minutes Diabetes & Cellulitis Acute Hypoglycemia	<ul style="list-style-type: none"> Conduct assessment Perform fingerstick blood glucose check Recognize hypoglycemia Administer juice, low-fat milk, or IV glucose Reassess blood glucose level Provide patient education and support Access and document care in EMR 	Patient with diabetes is admitted for cellulitis of the foot. He experiences an episode of hypoglycemia. Primary diagnosis: Cellulitis Secondary diagnosis: Diabetes mellitus type 2	Learner assesses and manages care for a patient experiencing acute hypoglycemia.

Scenario	Patient Data Est. Scenario Time* Est. Debriefing Time*	Scenario Skills	Scenario Presentation and Diagnoses	Primary Simulation Challenge
MS-21 Advanced 	Harry George 54-year-old Male Scenario: 20-25 minutes Debriefing: 20-25 minutes Diabetes & Cellulitis Severe Acute Hypoglycemia	<ul style="list-style-type: none"> Conduct assessment Recognize unresponsiveness Call for help Perform glucose check Recognize hypoglycemia Notify provider Administer IV dextrose Provide patient education and support Access and document care in EMR 	Patient with diabetes is admitted for cellulitis of the foot. He experiences an episode of severe hypoglycemia and is found unresponsive with IV pulled out. Primary diagnosis: Cellulitis Secondary diagnosis: Diabetes mellitus type 2	Learner assesses and manages care for a patient experiencing severe acute hypoglycemia with unresponsiveness.
MS-22 Basic 	Barbara Jean Dolan 47-year-old Female Scenario: 15-20 minutes Debriefing: 15-20 minutes Pancreatitis Pain & Nausea	<ul style="list-style-type: none"> Conduct assessment Recognize pain and nausea Score findings on CIWA-Ar protocol Recognize that protocol does not indicate need for sedative Administer IV pain medication Administer IV antiemetic Provide patient education and support Access and document care in EMR 	Patient with active alcohol abuse problem is admitted with acute pancreatitis and pain. Patient complains of pain and nausea. Primary diagnosis: Acute pancreatitis Secondary diagnosis: Alcohol abuse	Learner assesses and manages pain and nausea for patient experiencing pancreatitis. Learner uses the CIWA-Ar alcohol withdrawal protocol to guide treatment decisions.
MS-23 Advanced 	Barbara Jean Dolan 47-year-old Female Scenario: 15-20 minutes Debriefing: 15-20 minutes Pancreatitis Alcohol Withdrawal	<ul style="list-style-type: none"> Conduct assessment Recognize signs and symptoms of alcohol withdrawal Use therapeutic communication Identify IV removed by patient Score findings on CIWA-Ar protocol Recognize that protocol recommends administration of sedative Administer IM lorazepam or start new IV and administer IV lorazepam Provide patient education and support Access and document care in EMR 	Patient with active alcohol abuse problem is admitted with acute pancreatitis and pain. Patient begins to show signs and symptoms of alcohol withdrawal and has removed IV. Primary diagnosis: Acute pancreatitis Secondary diagnosis: Alcohol abuse	Learner assesses and manages care for a patient experiencing alcohol withdrawal.
MUSCULOSKELETAL				
MS-24 Basic 	Clarence Hughes 73-year-old Male Scenario: 25-30 minutes Debriefing: 25-30 minutes Knee Arthroplasty Blood Transfusion	<ul style="list-style-type: none"> Conduct assessment Recognize fatigue and low hemoglobin and hematocrit levels Notify provider of status Initiate blood transfusion per protocol Monitor blood transfusion Manage blood transfusion reaction (optional) Provide patient education and support Access and document care in EMR 	Patient experiences fatigue and low hemoglobin and hematocrit levels after blood loss during knee replacement surgery. Primary diagnosis: Osteoarthritis Secondary diagnosis: Glaucoma	Learner assesses and manages care for a patient requiring a blood transfusion. (Optional additional scenario challenge: Learner manages a blood transfusion reaction.)

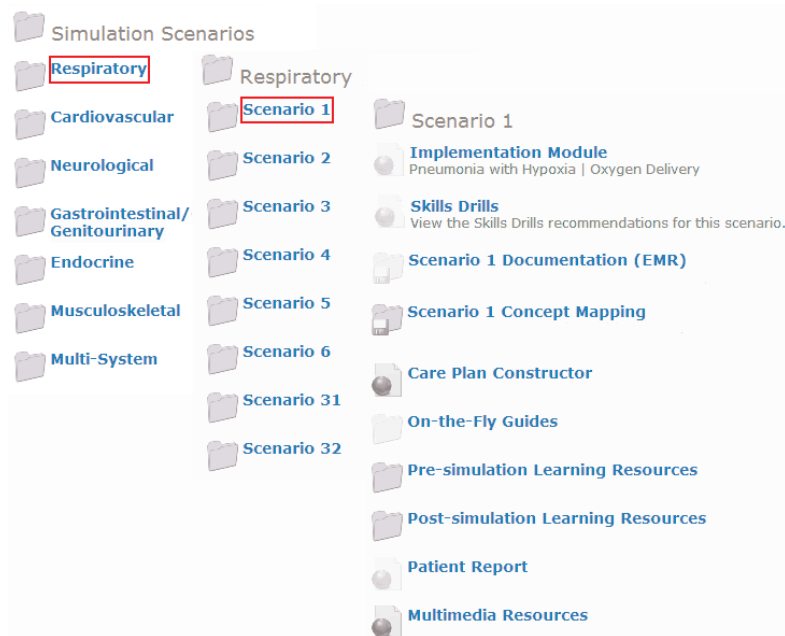
Scenario	Patient Data Est. Scenario Time* Est. Debriefing Time*	Scenario Skills	Scenario Presentation and Diagnoses	Primary Simulation Challenge
MS-25 Advanced 	Clarence Hughes 73-year-old Male Scenario: 30-35 minutes Debriefing: 30-35 minutes Knee Arthroplasty Pulmonary Embolism	<ul style="list-style-type: none"> Conduct assessment Recognize signs and symptoms of pulmonary embolism Administer supplemental oxygen Notify provider of status Elevate head of bed Coordinate blood work, x-ray, and CT scan and communicate results Administer IV heparin bolus and infusion Provide patient education and support Access and document care in EMR 	Patient complains of sudden chest pain and shortness of breath 3 days after knee replacement surgery. Primary diagnosis: Osteoarthritis Secondary diagnosis: Glaucoma	Learner assesses and manages care for a patient experiencing a pulmonary embolism. Communicates multiple times with provider while coordinating care.
MS-26 Basic 	Kathryn Doyle 79-year-old Female Scenario: 20-25 minutes Debriefing: 20-25 minutes Hip Fracture Postoperative Bleed	<ul style="list-style-type: none"> Conduct assessment Recognize hypotension and bleeding Notify provider of status Initiate IV fluid bolus per order Reinforce surgical dressing Provide patient education and support Access and document care in EMR 	Patient returns to inpatient unit after hip surgery and experiences hypotension and bleeding. Primary diagnosis: Left hip fracture Secondary diagnosis: None	Learner assesses and manages care for a patient experiencing postoperative bleeding.
MS-27 Advanced 	Kathryn Doyle 79-year-old Female Scenario: 20-25 minutes Debriefing: 20-25 minutes Hip Fracture Wound Infection & Early Sepsis	<ul style="list-style-type: none"> Conduct assessment Recognize signs and symptoms of wound infection and early sepsis Notify provider of status Collect wound and blood cultures per order Provide wound care per order Administer IV antibiotic per order Provide patient education and support Access and document care in EMR 	Patient experiences wound infection and early sepsis 4 days after hip surgery. Primary diagnosis: Left hip fracture Secondary diagnosis: None	Learner assesses and manages care for a patient experiencing a surgical wound infection and early sepsis.
MS-28 Basic 	Carmen Gonzales 56-year-old Female Scenario: 15-20 minutes Debriefing: 15-20 minutes Osteomyelitis with Wound Debridement Pain Management	<ul style="list-style-type: none"> Conduct immediate postoperative assessment Recognize postoperative wound pain Recognize patient's reluctance to use pain medications Counsel patient on pain medication risks and benefits Provide non-pharmacologic pain relief options Administer IV morphine per order as desired by patient Provide patient education and support Access and document care in EMR 	Patient admitted for wound debridement of gangrenous leg experiences postoperative wound pain and expresses reluctance to use pain medications. Primary diagnosis: Osteomyelitis and gangrene of left leg Secondary diagnosis: Diabetes mellitus type 2, coronary artery disease, heart failure, hypertension	Learner completes post-operative assessment and provides counseling and care for patient experiencing pain but expressing reluctance to use pain medications.

Scenario	Patient Data Est. Scenario Time* Est. Debriefing Time*	Scenario Skills	Scenario Presentation and Diagnoses	Primary Simulation Challenge
MULTISYSTEM				
MS-29 Basic 	Jose Carlos 20-year-old Male Scenario: 20-25 minutes Debriefing: 20-25 minutes Hemothorax with Chest Tube Wound Infection	<ul style="list-style-type: none"> Conduct assessment Recognize pain and other signs and symptoms of wound infection Notify provider Administer pain medication and acetaminophen Collect wound and blood cultures per order Provide wound care per order Administer IV antibiotic per order Provide patient education and support Access and document care in EMR 	Patient with resolving hemothorax after gunshot wound to chest develops an infection at entry site and experiences pain. Primary diagnosis: Hemothorax Secondary diagnosis: Gunshot wound to chest	Learner assesses and manages care for a patient experiencing a gunshot wound infection.
MS-30 Advanced 	Jose Carlos 20-year-old Male Scenario: 20-25 minutes Debriefing: 20-25 minutes Hemothorax with Chest Tube Drug Overdose	<ul style="list-style-type: none"> Conduct assessment Recognize vital signs within expected limits and no signs of oversedation Administer IV morphine per PRN order Recognize respiratory depression Recognize possible illicit drug use as contributing to overdose Notify provider Administer IV naloxone per order Provide patient education and support Access and document care in EMR 	Patient experiences respiratory depression immediately after learner administers IV narcotic. Patient reveals to learner that he also recently ingested unknown drugs provided to him by visiting friends. Primary diagnosis: Hemothorax Secondary diagnosis: Gunshot wound to chest	Learner assesses and manages pain with prescribed IV narcotic, and respiratory distress occurs immediately. Learner discovers that patient recently ingested unknown drugs provided by visiting friends. Learner manages narcotic overdose.
MS-35 Basic 	James Story 42-year-old Male Scenario: 15-20 minutes Debriefing: 15-20 minutes Urinary Tract Infection Disruptive Family Member	<ul style="list-style-type: none"> Conduct assessment Recognize elevated temperature Identify inability to void Manage disruptive family member Perform straight catheterization and obtain urine sample Administer antipyretic per PRN order Provide patient education and support Access and document care in EMR 	Patient admitted for suspected urinary tract infection is experiencing elevated temperature and inability to void. Orders exist for urine sample via catheterization if unable to void. Primary diagnosis: Fever of unknown origin Secondary diagnosis: Diabetes mellitus type 1, end-stage renal disease	Learner assesses and manages care for a patient with end-stage renal disease experiencing a suspected urinary tract infection. Learner also manages a family member who becomes physically disruptive during catheterization.
MS-36 Advanced 	James Story 42-year-old Male Scenario: 15-20 minutes Debriefing: 15-20 minutes Urinary Tract Infection Anaphylactic Reaction	<ul style="list-style-type: none"> Conduct assessment Recognize signs and symptoms of anaphylactic reaction Stop IV antibiotic Administer supplemental oxygen Notify provider Administer SQ epinephrine Provide patient education and support Access and document care in EMR 	Patient being treated for a urinary tract infection experiences an anaphylactic reaction to an IV antibiotic. Primary diagnosis: Fever of unknown origin Secondary diagnosis: Diabetes mellitus type 1, end-stage renal disease	Learner assesses and manages care for a patient experiencing an anaphylactic reaction to an IV antibiotic.

* Scenario and debriefing times are estimated based on field testing results.

The actual simulation scenarios may be accessed through the folder  labeled *Simulation Scenarios*. From there, select the scenario you wish to open.

PATHWAY TO THE SCENARIO



SIMULATION LEARNING SYSTEM

PNEUMONIA
Oxygen Delivery

PREPARATION ▼ SCENARIO ▼ DEBRIEFING ▼ RESOURCES ▼


Scenario Overview

Screen 01 of 19 **NEXT ►**

Level
Basic medical-surgical

Purpose
To provide students with the opportunity to assess, intervene, and manage care for a patient experiencing mild hypoxia and fever.

Overview
Patricia Newman is a 61-year-old female with a 12-year history of emphysema who presented to the emergency department at 0100 on Tuesday morning with moderate respiratory distress, a productive cough, and a fever. She was admitted to the inpatient medical-surgical unit for treatment of pneumonia. The scenario takes place at 1630 on Tuesday afternoon, at which time Patricia Newman has just returned from the pulmonary function lab. Upon her transfer to bed, the oxygen flow to her nasal cannula was accidentally discontinued, and she is complaining of shortness of breath. She is also complaining of discomfort related to an elevated temperature. During this scenario, students will have the opportunity to prioritize and implement nursing care for a patient experiencing mild hypoxia and fever.



Recommended scenario time limit: 20-30 minutes

Recommended debriefing time limit: 20-30 minutes

NEXT ►

SLS Implementation Module

The SLS is set up identically for each scenario. Once you become familiar with how the materials are organized for one scenario, you'll easily be able to navigate through the rest. The following sections detail the SLS resources available within each scenario *Implementation Module*.






IMPLEMENTATION MODULE OVERVIEW

Each scenario *Implementation Module* is organized into four main tabs that house the preparation, scenario, debriefing, and supplemental resources for the scenario. Within these tabs you will find all of the instructions, details, and resources necessary for implementing the scenario.

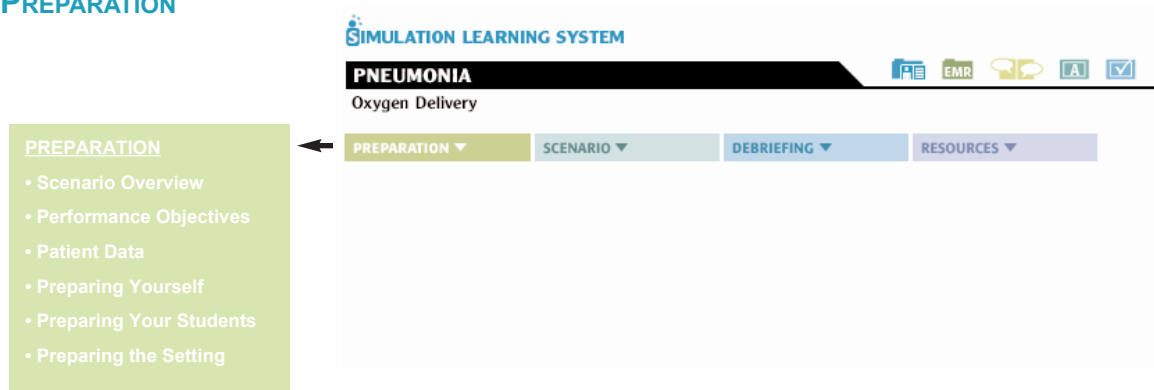


1. **Preparation** resources are for pre-simulation planning and preparation.
2. **Scenario** resources assist during simulation implementation.
3. **Debriefing** resources facilitate discussion and evaluation post-simulation.
4. **Resources** are additional items to facilitate student understanding.

In addition to these four main tabs, five quick-access icons are displayed in the scenario header of the *Implementation Module*. These icons offer easy access to frequently used resources.

- A. The **Facilitator's Packet**  is a convenient printable PDF that includes resources needed for preparation and implementation of the scenario. The resources in the **Facilitator's Packet** are located in various places within the *Implementation Module* and compiled here for easy reference. A link to the **Facilitator's Packet** is also found under the *Preparing Yourself* screen of the **Preparation** tab.
- B. The **Electronic Medical Record (EMR)**  is a fully interactive medical record that the learner will use to reference and document patient data before, during, and after the scenario. This quick-access icon is the main faculty access point for the **EMR**.
- C. The **Patient Report**  summarizes the patient's condition immediately before the scenario begins. This report is used to initiate the simulation experience. A link to the **Patient Report** is also found on the *Initiating the Simulation Experience* screen of the **Scenario** tab.
- D. The **Algorithm Quick Card**  provides the facilitator with a visual progression of the scenario. A link to the **Algorithm Quick Card** is also found on the *Scenario Phase I: Introduction* screen of the **Scenario** tab.
- E. The **Performance Checklist**  may be used for evaluation of student actions during the scenario. A link to the **Performance Checklist** is also found on the *Scenario Phase I: Introduction* screen of the **Scenario** tab.

1. PREPARATION

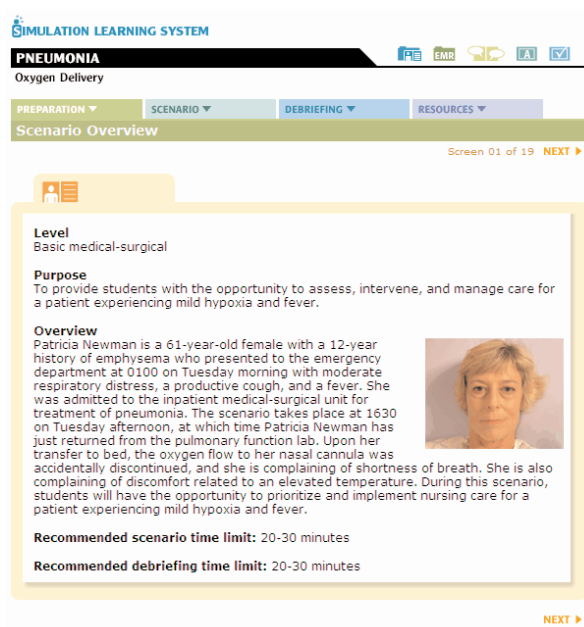


Scenario Overview

Title. The scenario title, located just to the left of the quick-access links, reflects the patient's medical condition. For students, scenarios are referred to by number and patient name only, so as not to reveal too much about the simulation experience.

Purpose. The scenario purpose reflects the nursing actions that the student will perform during the scenario. This purpose closely mirrors the nursing process in that the student must assess, plan, intervene, and evaluate the effect of the nursing interventions.

Overview. The scenario overview offers a brief sketch of the patient and the events occurring before the scenario start time. A description of the patient upon initial contact is also provided, along with the nursing actions to be performed.



Recommended Scenario and Debriefing Time Limit. Recommended scenario and debriefing time limits are identified on the first screen, with suggested times based on the number of performance objectives for each simulation scenario and the scenario phases. The facilitator must remain flexible, however, because student performance during the simulation scenario is not always predictable. The struggling student may take longer to achieve the performance objectives of a given simulation scenario, whereas the more experienced or confident student may progress more quickly. Therefore, it may be helpful to allow extra time when scheduling. These times are estimated based on SLS field testing.

Performance Objectives

The **Performance Objectives** consist of identifiable actions that the student should perform during the scenario or after in the debriefing discussion. These objectives are based on the nursing process and are organized according to the Quality and Safety Education for Nurses (QSEN) quality and safety competencies. Specific nursing actions are listed in the **Performance Objectives** section to guide the facilitator in choosing the most appropriate simulation scenario for the student's skill level. The **Performance Objectives** correlate closely with the objectives in the **Performance Checklist** (see page 34). However, the checklist has been organized chronologically for trouble-free student evaluation.

Patient Data

The patient's name, medical record number, date of birth, gender, admitting health care provider, chief complaint upon admission to the health care facility, and primary and secondary diagnoses are listed here, closely mirroring the medical record in the real-world clinical environment.

Scenario Start Day and Time. The scenario start day and time reflect the exact time that the student encounters the patient during the simulation scenario. The corresponding **EMR** reflects patient data collected up to the start time of the scenario, again recreating the real-life clinical environment. Students have the opportunity to document in the **EMR** the events that occur during the scenario, beginning with the start day and time.

Preparing Yourself

Preparation is the key to success in clinical simulation and ensures that the simulation scenario runs smoothly for you and your students. Before running an SLS scenario with students, you should review the complete **Implementation Module** of each scenario so that you are familiar with all aspects of the simulation scenario and its related resources. In addition, try to schedule some time with colleagues or a small group of students to do a "practice run" of the scenario before implementation with a large group of students. Familiarization with the essential elements of each scenario will assist in the successful implementation of clinical simulation throughout the curriculum.

PREPARATION ▾

SCENARIO ▾

DEBRIEFING ▾

RESOURCES ▾


Performance Objectives

◀ PREVIOUS

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NEXT ▶

The identifiable actions that the student is expected to perform during this scenario are based on the nursing process and have been organized according to the Quality and Safety Education for Nurses (QSEN) quality and safety competencies.



The student will:

- Provide individualized patient-centered care by:**
 - Conducting a focused assessment
 - Providing individualized teaching
- Function effectively as a member of the health care team by:**
 - Independently initiating care within nursing scope of practice
- Implement best clinical practices by:**
 - Recognizing abnormal findings:
 - Dyspnea
 - Decreased oxygen saturation level
 - Elevated respiratory rate
 - Confusion
 - Elevated temperature
 - Prioritizing and implementing appropriate interventions:
 - Recognizing and fixing disconnected oxygen tubing
 - Administering acetaminophen
 - Integrating current evidence-based research into clinical decision-making
- Promote safety for patient, self, and others by:**

PREPARATION ▾

SCENARIO ▾

DEBRIEFING ▾

RESOURCES ▾

Patient Data

◀ PREVIOUS

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NEXT ▶



Location: Inpatient, Medical-surgical unit

Patient name: Patricia Newman

Medical record #: 1868097

Date of birth: June 6

Age: 61

Sex: Female

Admitting physician: Joseph Molina, MD

Scenario start day: Day 1, Tuesday

Scenario start time: 1630

Chief complaint upon admission: Productive cough and fever

Primary diagnosis: Pneumonia

Secondary diagnosis: Emphysema



◀ PREVIOUS

NEXT ▶

PREPARATION ▾

SCENARIO ▾

DEBRIEFING ▾

RESOURCES ▾

Preparing Yourself

◀ PREVIOUS

Screen 04 of 19

NEXT ▶

This module provides a framework for successful implementation of **Scenario 1** with step-by-step instructions from preparation to debriefing and follow-up.



Facilitator Action

- Download and print the **Facilitator's Packet**. Resources included in this packet are marked with an icon (📎) throughout the module for quick reference:
 - Staging Instructions
 - Patient Identity Band
 - Patient Report
 - Patient Response Guide
 - Additional Participant Response Guide
 - Participant Role Badges
 - Observer Evaluation Rubric
 - Algorithm Quick Card
 - Performance Checklist

◀ PREVIOUS

NEXT ▶

Following the review of materials and practice session, determine how the simulation scenario will be scheduled and managed with all students. For example, you may choose to run each scenario with small groups of 4 to 5 students with assigned roles, or you may prefer to run a simulation scenario with a few students while projecting the real-time simulation to a classroom using audio-visual equipment. Some facilitators may choose to run the simulation scenario with their designated clinical groups. However you choose to implement the simulation scenarios, this should be determined and communicated to students before initiating the simulation.

The **Facilitator's Packet** is a printable PDF file designed to assist facilitators before and during clinical simulation and includes information needed to prepare the setting, communicate important information to students, and evaluate student performance. The **Facilitator's Packet** can be downloaded and printed from the *Preparing Yourself* screen or accessed by clicking on the quick-access icon  in the upper right hand corner of the **Implementation Module** screen. The icon  appears throughout the **Implementation Module** next to any specific resources that can be found within the **Facilitator's Packet**.


FACILITATOR'S PACKET

The **Facilitator's Packet** contains the **Scenario Overview**, **Staging Instructions**, **Identity Bands**, **Patient Report**, **Patient Response Guide**, **Additional Participant Response Guide(s)**, **Participant Role Badges**, **Observer Evaluation Rubric**, **Algorithm Quick Card**, and **Performance Checklist**.

The Scenario

The scenario purpose, overview, and time limit is the same as that found on the *Scenario Overview* screen under the **Preparation** tab.

Scenario 1



Pneumonia with Hypoxia | Oxygen Delivery


Level
Basic medical-surgical

Purpose
To provide students with the opportunity to assess, intervene, and manage care for a patient experiencing mild hypoxia and fever.

Overview
Patricia Newman is a 61-year-old female with a 12-year history of emphysema who presented to the emergency department at 0100 on Tuesday morning with moderate respiratory distress, a productive cough, and a fever. She was admitted to the inpatient medical-surgical unit for treatment of pneumonia. The scenario takes place at 1630 on Tuesday afternoon, at which time Patricia Newman has just returned from the pulmonary function lab. Upon her transfer to bed, the oxygen flow to her nasal cannula was accidentally discontinued, and she is complaining of shortness of breath. She is also complaining of discomfort related to an elevated temperature. During this scenario, students will have the opportunity to prioritize and implement nursing care for a patient experiencing mild hypoxia and fever.

Recommended scenario time limit: 20-30 minutes

Recommended debriefing time limit: 20-30 minutes



Staging Instructions

The physical simulation environment must be conducive to learning. One primary purpose of simulation is to engage students in a challenging, realistic situation, and to allow them to interact with the physical environment, as well as the patient, when managing the situation. Maintaining an organized and well-equipped physical environment will facilitate learning and enhance knowledge transfer to the clinical setting. The SLS Home Page provides a link to **Simulation Center Resources**, which include many resources that may help you in planning and preparing the physical simulation environment.

Simulation labs may be equipped with human patient simulators created by different manufacturers with varying functionalities. Facilitators should make every effort to orient themselves to the particular human patient simulator used in their own simulation laboratory and gain mastery of its functionalities and technical operations. It can be especially helpful for your nursing program to enlist one or more “champions” of clinical simulation as experts in the implementation of simulation and to coordinate clinical simulation activities with other facilitators.

The **Staging Instructions** provide detailed information regarding the scenario-specific props—including equipment, supplies, and medications—necessary for scenario implementation. Instructions regarding the use and placement of these props for scenario staging are included.

In some scenarios, paper resources or forms will be required as props. Any required resources or forms are included within the *Facilitator's Packet* and appear as links in the *Preparing the Setting* screen of the *Implementation Module*. Simply click on the link and print the required materials.

Staging Instructions

Props

Equipment/supplies:

- IV angiocatheter, 20-gauge
- IV dressing supplies
- IV tubing, primary and secondary
- IV pump
- Nasal cannula and tubing x 2
- 2 pillows
- Incentive spirometer
- Patient identity band
- EMR

Medications:

- 1000 mL IV bag of dextrose 5% in 1/2 normal saline with potassium chloride 40 mEq/L
- Acetaminophen 325 mg tablets
- Estradiol transdermal patch 0.05 mg
- Empty IV piggyback bag of levofloxacin 750 mg in 150 mL dextrose 5% in water, correctly labeled with patient information; time of last dose: Tuesday 0600 (optional, suggested to add reality to scene)
- Ipratropium 18 mcg/puff metered-dose inhaler (distracter)
- Calcium carbonate 600 mg tablets (distracter)

Optional:

- Reference materials (e.g., lab book, drug book, normal lab values)

Facilitator Action

Prepare the simulator to reflect the specifications of the scenario:

1. Change simulator to female sex.
2. Apply correct patient identity band.
3. Dress simulator in gown and position supine in bed with head of bed at 15 degrees. Place 2 pillows beneath head.
4. Insert IV angiocatheter in right forearm, secure with dressing, and infuse dextrose 5% in 1/2 normal saline with potassium chloride 40 mEq/L at 75 mL/hr.
5. Place nasal cannula in bed underneath the patient's pillow and connect tubing to oxygen flow meter on wall at 2 L/min.
6. Place second nasal cannula on patient and connect tubing to a portable oxygen cylinder that is turned off. (Patient should be receiving no supplemental oxygen.)
7. Apply estradiol patch to abdomen of simulator.
8. Hang empty, previously administered IV piggyback bag of levofloxacin on IV pole as if it had been properly administered (optional).
9. Place incentive spirometer on bedside table.
10. Stock supply cart with standard equipment (see implementation guide).
11. Stock medication cart with listed medications.
12. Position chair at bedside for patient's neighbor.

In addition to scenario-specific props, the simulation area should be stocked with standard props. These standard props include items commonly found in a patient care setting. Since standard props are not usually listed on the scenario-specific **Staging Instructions**, take time to be sure that all standard props are in place when staging each scenario. It may be helpful to print a copy of the standard props list included here to use as a checklist for each scenario.

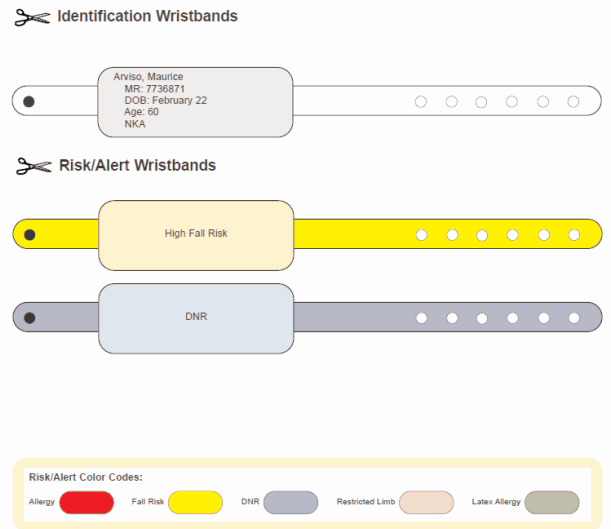
Standard Props and Equipment for All Scenarios		
Supplies: <ul style="list-style-type: none"> • Hand sanitizer or hand washing station • Universal precaution supplies: clean gloves (all sizes), gowns, masks, face shields, or goggles • Saline flush syringes (for IV flushes) • Alcohol wipes • Cotton balls • Clean gauze squares • Bandages • Tape • Scissors • Box of tissues • Peripads • Bed pads • Sterile gloves in all sizes • Supply cart (optional, for organization of supplies) • Medication cart with simulated medications (see each scenario list for specific medications) 	Patient care equipment: <ul style="list-style-type: none"> • Functioning bed • Extra pillows • Sphygmomanometer • Stethoscope (or student to provide) • Thermometer • Pulse oximeter • Cardiac monitor • Oxygen source (wall mount or tank) • Oxygen flow meter • Nasal cannula and tubing • Oxygen face mask • Bag-valve mask • Suction equipment (wall mount or portable) 	Additional equipment in or near patient room: <ul style="list-style-type: none"> • Telephone (for provider or interprofessional calls) • Regular garbage bin • Biohazard garbage bin • Linen bag or bin • Sharps container • Writing surface • Pen and note paper • Calculator • Chair for visitor • Laptop or desktop computer with internet connection (for the Electronic Medical Record)

Depending on the type of human patient simulator being used and the type of equipment available in your simulation setting, creative moulage may be necessary. The **Staging Instructions** may specify a particular patient presentation, such as type of wound or bloody discharge. When these specifications cannot be met with standard simulator settings, it may be necessary to improvise in order to create the best possible simulation environment. Suggestions for alternative moulage or equipment work-arounds have been supplied when available. Following the guidelines where possible - and using creativity when the guidelines cannot be followed - will ensure a quality simulation learning environment for your students.

Because the **EMR** is an essential component of patient care, it is necessary to provide internet access for student access to the **EMR** during the scenario. Access to the **EMR** will allow students to review patient data or reference orders during the scenario, as well as to practice documentation during or immediately following the scenario.

Identity Bands

In order to closely mimic the real-life clinical environment, the *Facilitator's Packet* provides **Identity Bands** appropriate to the scenario. Provided bands include *Patient Identity*, *Allergy*, and other *Risks/Alerts*. Correct identification of a patient reduces the risk for errors in the clinical setting. Utilizing these bands during simulation allows students to practice this skill with each scenario in order to promote patient safety. The bands are designed to be cut out and used during the simulation. Facilitators may find it useful to laminate the bands and store them with scenario-specific documents and materials for future use.




Patient Band	White	Name Medical record number Date of birth Age
Risk/Alert: Allergy	Red	Band indicates that patient has allergy identified
Risk/Alert: Fall Risk	Yellow	Band indicates that patient has determined fall risk
Risk/Alert: DNR	Purple	Band indicates that patient has a do not resuscitate order
Risk/Alert: Restricted Limb	Pink	Band indicates that limb to which band is placed has restricted access
Risk/Alert: Latex Allergy	Green	Band indicates that patient has a latex allergy

Patient Report

Clear communication of patient information during hand-off or at the change of shift is essential to error prevention in the clinical setting. The **Patient Report** offers detailed information, in SBAR format, regarding the patient's situation, background, and assessment findings, as well as recommendations for care.

The **Patient Report** may be accessed from three locations:

- From the icon  on the scenario header bar
- From the link on the *Implementing the Simulation Experience* screen
- From the scenario-specific **Facilitator's Packet**

The **Patient Report** provides students with a current patient status update and sets the stage for the scenario. Facilitators may choose to present the report to their students themselves, or to have a student play the role of the nurse providing the report. The report may be reviewed in written form, read aloud as if in a report room, or communicated at the patient's bedside. Regardless of the delivery method, this report must be provided to students before the start of the scenario. This simulates an actual patient report given when one nurse accepts patient care from another and leads the learner into the simulation scenario.

Patient Report

SBAR Hand-Off	Current day and time:	Tuesday 1630	Admission day and time:	Tuesday 0100 to the emergency department Tuesday 0800 to the inpatient unit
Situation	Name:	Patricia Newman		
	Age:	61	Sex:	Female
	Ethnicity:	Caucasian	Religion:	Christian
	Provider:	Joseph Molina, MD		
	Admission diagnosis:	Pneumonia		
Background	Pertinent medical history:	12-year history of emphysema. History of osteoporosis and hypertension. Hysterectomy 8 years ago. Multiple hospitalizations for pneumonia in the past 2 years. Smokes 2 packs of cigarettes per day.		
	Pertinent social history:	Divorced, lives alone		
	Allergies:	No known allergies		
	Code status:	Full code		
	Vital signs (most recent):	Time: 1300	T: 101.2 F (38.4 C)	BP: 148/82
	Oxygen therapy:	Mode:	Nasal cannula	LPM: 2
	Pain:	Rating: 0	Most recent pain medication:	None
	Other recent medication:	Regular blood pressure medications in morning per her usual routine		
	I/Vs:	Site: Right forearm	Type: Peripheral IV	Assessment: Patent, intact
	Fluids:	Dextrose 5% in 1/2 normal saline with 40 mEq potassium chloride per liter at 75 mL/hr		
	Drains and tubes:	Site: None	Type: Not applicable	Assessment: Not applicable
	Wounds:	Site: None	Type: Not applicable	Assessment: Not applicable
	ADLs:	Diet: Regular diet, no added salt	Activity:	Amble as tolerated. She has been up once today. She tires easily.
	Restrictions:	Isolation: Standard precautions	Fall risk:	Moderate
	Assessments:	Neurologic: Alert and oriented; slight confusion at times		
		Cardiac: Regular rate and rhythm; mild tachycardia		
		Respiratory: Lungs coarse. Productive cough present with thick, yellow sputum. Her oxygen saturation levels drop with exertion or when the supplemental oxygen is removed.		
		GI/GU: No issues		
		Integumentary: Intact		
		Ortho/Mobility: Mild dyspnea present upon exertion. Patient has slight weakness; independent with assist of one.		
		Psychosocial: Patient appears frustrated with her current condition.		
		Other: Patient is quite thin. A dietary consult has been completed.		
	Labs and diagnostics:	Arterial blood gases were completed this morning. A chest x-ray was done in the emergency department and was indicative of pneumonia. White blood cell count this morning was 16,000; potassium was 3.2. The IV fluid was changed to include more potassium. A sputum Gram stain returned positive and the culture is still pending. The provider is aware of all of these results.		
Assessment	Nurse's assessment:	Patient is stable and resting.		
Recommendation	Plan of care:	IV antibiotics, IV hydration, and pulmonary rehabilitation; encourage ambulation as tolerated		
	Tests/results pending:	None		
	Orders pending completion:	None		
	Other:	Mrs. Newman just returned from the pulmonary function lab. The transport team settled her in. I haven't had time to see her since she returned. Her neighbor Diane just arrived to visit her and is in the room with her now.		

Patient Response Guide

The **Patient Response Guide** offers questions, comments, and responses that the patient might make during the scenario. Some responses are intended to provide the student with information, such as clinical findings or data, while other responses, such as questions about interventions, are intended to challenge or cue the student to interact with the patient. Responses are organized into categories so that the facilitator can quickly locate the appropriate response.

The **Patient Response Guide** has been scripted to reflect the patient's clinical condition and anticipated issues. These general responses are provided as a framework, with the understanding that student questions and actions are often unpredictable. The facilitator is encouraged to improvise and add appropriate impromptu responses on behalf of the patient when necessary.

Patient Response Guide

Patricia Newman is a 61-year-old Caucasian female admitted with pneumonia. She has a history of emphysema. At the start of the scenario, she has just returned from the pulmonary function lab. She is febrile and uncomfortable. During the transfer back to bed, her oxygen cannula was not reconnected correctly, and she is currently receiving no supplemental oxygen through her nasal cannula. During the scenario, Mrs. Newman becomes increasingly confused and disoriented as her oxygen saturation level falls. Her neighbor Diane is in the room with her and expresses concern when Patricia is unable to recognize her.

General	<ul style="list-style-type: none"> • My name is Patricia Newman. • My birthday is June 6. • I don't have any allergies. • I am 61 years old. • I don't have any pain.
During initial assessment	<ul style="list-style-type: none"> • Patricia begins the scenario mostly alert and oriented, but begins to develop confusion if oxygen is not reconnected. • I just got back from a test and a nice man helped me back to bed. • Where am I? Am I in a hotel? Who are you? • It's a little hard to catch my breath, but that's what this oxygen is for. • I feel hot.
If oxygen is reconnected and oxygen saturation level increases	<ul style="list-style-type: none"> • My name is Patricia Newman, and I am in the hospital for pneumonia. • It is... Tuesday, I think. • I can catch my breath now. • Thank you for helping me.
If oxygen is NOT reconnected and oxygen saturation level falls	<ul style="list-style-type: none"> • As her oxygen saturation level falls, Patricia becomes more confused, anxious, and belligerent. • My name is Patricia (deep breath). • I don't know what day or time it is (deep breath). • I don't know where I am or what I am doing here (deep breath). • (To neighbor Diane) Who are you? You look familiar, but I can't remember. • It's hard to breathe (deep breath). Can you help me? • Leave me alone and let me catch my breath (deep breath). • I can't breathe (deep breath).
If acetaminophen is administered	<ul style="list-style-type: none"> • Patricia expresses relief and gratitude. • Thank you. This should help me feel better.
If acetaminophen is NOT administered	<ul style="list-style-type: none"> • Patricia complains of fever-related discomfort. • I feel so hot and uncomfortable. • I must be running a fever. I feel terrible. • Is there anything you can do about this fever?

Additional Participant Response Guide

Additional participant(s) may be family members, friends, a physician, or another person who is present either physically or by telephone during the simulation. The **Additional Participant Response Guide** provides a script for the person assigned to the particular role. Print out or copy the **Additional Participant Response Guides** and provide them to participants at the time of the scenario.

Family Member or Friend. Student participants, faculty or staff members, or volunteers may be assigned the role of family member or friend of the patient. The person playing this role should be given adequate time to review the **Additional Participant Response Guide** and prepare to use the guide to provide appropriate responses and comments during the scenario. Playing the role of a family member may provide the student insight into the feelings of a visitor in a health care environment. The thoughts and emotions of the visitor should be discussed during the debriefing session, and discussions of the importance of therapeutic communication with both the patient and family member or friend should be encouraged.

Additional Participant Response Guide

Patient's Neighbor: Diane Ernst
Patricia Newman's concerned neighbor, Diane, is present to visit Patricia upon her return from the pulmonary function lab. Diane has just learned that Patricia was admitted to the hospital today and has come to check on her. Diane has lived next door to Patricia for the past 15 years, and they are close friends and travel together on vacation at least once a year. She becomes very inquisitive during the visit, especially when Patricia does not recognize her.

General	<ul style="list-style-type: none"> Diane is inquisitive. How is Patricia doing? When will she be able to go home? Don't worry, Patricia. I'll help you when you get back home. What is the plan for her here in the hospital? What medications is she taking to help her recover? Will she have to be on oxygen when she goes home?
If Patricia becomes confused and short of breath	<ul style="list-style-type: none"> Diane is very concerned when Patricia does not recognize her. She refuses to leave the bedside and demands that someone help Patricia. Patricia, don't you know me? I'm Diane. My goodness, you know me better than your own family! Why is she so confused? This is not like her. Is she taking a lot of pain medication? Is that making her confused? What is going on? Why is it hard for her to breathe? Isn't she on oxygen? You have to help Patricia. Something is really wrong.
If the nurse reconnects the oxygen and Patricia's status improves	<ul style="list-style-type: none"> Diane is grateful and curious about what happened. Thank you for helping Patricia. Is it normal for people to get confused if they aren't getting enough oxygen? Why does the pneumonia make it hard for her to get enough oxygen? Thank goodness you were here. That was very worrisome.

Ancillary Personnel. Student participants in ancillary personnel roles, such as the secondary nurse or nursing assistant, should be instructed to provide care within that provider's scope of practice. If indicated in the response guide, or to guide the direction of the scenario, the facilitator should prompt the secondary nurse and assistive personnel to enter the room or conduct a certain action depending on the events occurring in the scenario. In most scenarios, no response guide is provided for ancillary personnel unless a specific action is required of that person during the scenario. Students in ancillary personnel roles are expected to take direction from the primary nurse and complete tasks appropriately. It may be challenging for some students to maintain an ancillary role during a scenario when they are accustomed to acting as a nurse; students should be reminded during orientation to limit their interventions to the scope of practice of the ancillary care provider during the simulation. Issues that arise during simulation related to an individual's scope of practice and responsibilities during patient care may make for rich discussion during the debriefing session.

Physician or other Health Care Provider.

Students should be informed during orientation that they may need to contact the patient's physician or other health care provider to provide a status update or to obtain verbal orders during the course of the scenario. Communication may be obtained through a telephone line, paging system, in-person communication, or two-way walkie-talkies, depending on the scenario and your simulation facility's design and resources.

Additional Participant Response Guide

Patient's Physician: Dr. Arthur Kelly
Jacqueline Cantanazaro's emergency department physician, Dr. Arthur Kelly, should be contacted with a patient status update in SBAR format. He is aware of the patient's situation and background, but still requires a complete report of the immediate situation. If the report is incomplete, the physician should prompt the student for the missing pieces. If the report is complete, the physician should provide orders.

If the SBAR report is incomplete	<ul style="list-style-type: none"> Please give me more information regarding: <ul style="list-style-type: none"> your assessment. your recommendation.
If the SBAR report is complete	<ul style="list-style-type: none"> Thank you for the update.
Orders	<ul style="list-style-type: none"> Administer 60% to 100% oxygen via non-rebreather face mask. Maintain pulse oximeter readings of at least 92%. Follow current order for albuterol nebulizer treatments (5 mg albuterol via nebulizer every 20 minutes).

The role of the health care provider should be played by a facilitator or faculty member using the **Additional Participant Response Guide** for reference. Advance practice nursing students, medical students, or other similarly prepared students may also play this role; in general, it is not advisable to have nursing students play this role as it is beyond their scope of practice.

SBAR Communication. During communication with the physician or health care provider, students should be instructed to provide clear and concise communication regarding the patient condition in the format of **situation, background, assessment, and recommendation (SBAR)**. SBAR provides a framework for effectively communicating relevant patient information in an effort to minimize errors in the health care setting and optimize patient safety. When reporting about the **situation**, students should identify themselves

and the environment and provide clear information regarding the events occurring at the present time.

Background information includes the events leading up to the current situation, including the patient's diagnosis, medications, brief summary of hospitalization, recent vital signs, and other relevant clinical information. **Assessment** includes the student's analysis of the patient situation. Finally, students should give their **recommendation**, or what they feel can be done to improve the patient situation (for example, requesting an order for diagnostic tests or medications or demanding the patient be seen immediately).

The following is an example of nurse-to-provider communication in the SBAR format:

Situation: "Hello, Dr. Rebecca. I am Sarah Matthews, a nurse on unit 6G at Local Hospital. I'm caring for Ms. Ann Howard, who is experiencing a sudden onset of shortness of breath."


Background: "Ms. Howard is a 67-year-old female who was admitted from the emergency department for an exacerbation of her COPD last evening. She also has a history of hypertension. Following lab tests and a chest x-ray, she was placed on 2 liters of oxygen via nasal cannula and IV steroids. An antibiotic was started for treatment of possible bronchitis."

Assessment: "During my 7 AM assessment, I noted the following vital signs: temperature of 99.3° F, pulse of 114 bpm, shallow respirations of 26, and blood pressure of 148/86. Her pulse oximeter is reading 92%. She is moderately anxious and speaking in 2- to 3-word sentences. Bilateral breath sounds reveal wheezes throughout all lung fields. I have increased her oxygen flow rate to 4 liters via nasal cannula and am continuously monitoring her oxygen saturation."

Recommendation: "Since there is no order for bronchodilators on her chart, I am requesting an order to administer a fast-acting bronchodilator STAT. I will notify you with an update on her condition following the respiratory treatment."

Participant Role Badges

Role badges are provided for each scenario for participants, including primary nurse, secondary nurse, nursing assistant, health care provider, visitors, friends, and/or family members. Badges may be cut out and provided as identification props for the scenario. Like the armbands, facilitators may find it useful to laminate the role badges(s) and store them with scenario-specific documents and materials for future use.

 Participant Role Badges

Primary Nurse	Secondary Nurse
Patient's Sister: Joanne Hemphill	Patient's Physician: Dr. Arthur Kelly

Observer Evaluation Rubric

Created for the students who are observing the simulation, the **Observer Evaluation Rubric** helps student observers evaluate how well the primary nurse, secondary nurse, and other participant(s) meet or exceed expectations related to the core nursing competency areas. These areas include:

- Management of Care
- Safety and Infection Control
- Health Promotion and Maintenance
- Psychosocial Integrity
- Basic Care and Comfort
- Pharmacological and Parenteral Therapies
- Reduction of Risk Potential
- Physiological Adaptation

SLS Observer Evaluation Rubric

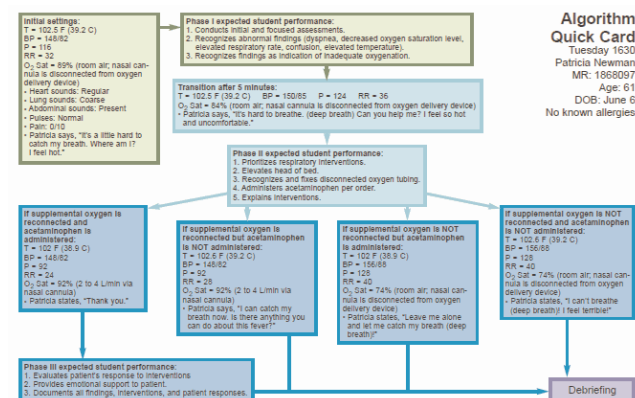
Observe the simulation scenario and assess the participants' management of the situation. Note areas in which participants performed well and areas in which they need improvement. Use these observations to provide feedback and participate in discussion during debriefing.

NCLEX® Client Needs Category	Exemplars observed during scenario:	Opportunities for improvement:
1. SAFE AND EFFECTIVE CARE ENVIRONMENT: MANAGEMENT OF CARE		
2. SAFE AND EFFECTIVE CARE ENVIRONMENT: SAFETY AND INFECTION CONTROL		
3. HEALTH PROMOTION AND MAINTENANCE		
4. PSYCHOSOCIAL INTEGRITY		


For each of these areas, evaluation criteria and expected activities are detailed. Information regarding the related QSEN competencies and national patient safety goals is also included. For ease of use, the **Observer Evaluation Rubric** should be printed out and provided to the student to write on during the scenario. If desired, each student may be assigned only one or two competency areas in order to help narrow the focus of their observation. The facilitator should encourage observers to share the results of their observations during the debriefing session.

Algorithm Quick Card

The **Algorithm Quick Card** is a one-page visual depiction of the three phases of the scenario designed as an easy reference for the simulation facilitator. The **Algorithm Quick Card** summarizes the patient progression, the student's expected actions, and the main possible scenario outcomes in a succinct, graphic representation. The facilitator should keep the card readily available as the scenario progresses and use it as a guide for transitioning the scenario from one phase to the next.



The **Algorithm Quick Card** may be accessed from several locations:

- The **Facilitator's Packet** for the scenario
- The **Scenario Phase I: Introduction** screen
- The **Algorithm Quick Card** quick-access icon  on the scenario header bar to the right of the scenario title

The **Algorithm Quick Card** is color-coded to provide a quick visual cue to the current simulation phase. Take a look at the example above:

PHASE I is the assessment stage. Phase I lists the initial patient settings and the expected student performance.

PHASE II is the intervention stage. Any changes in the patient's state from Phase I are noted here, along with the expected student performance for this phase. The student's interventions during Phase II will affect which route the patient will take going into Phase III.

PHASE III offers two or more patient outcomes depending on which interventions occurred during Phase II. Expected student performance statements are provided for when the student performs the appropriate interventions. If the student proceeds down the wrong route, the scenario can proceed directly to the debriefing stage.

The number of branches for any given scenario depends on:

- The complexity of the situation
- The number of appropriate interventions, and
- The number of possible outcomes

Vital sign data and patient presentation details are provided for all three phases of the scenario, although it is not expected that students necessarily assess this data during all three phases. Vital signs and patient details are provided so that the facilitator is able to program the manikin(s) and provide students with patient presentation details at any time the student chooses to assess the patient during the course of the scenario. Expected frequency of vital sign assessment will be dependent upon the individual scenario.

Although the quick card anticipates the most logical student response during the scenario, it is important that the facilitator remain alert to unanticipated student actions and adjust the simulator as necessary. At any point, the facilitator should be ready to manually change the parameters on the simulator to reflect the consequences of a student's action. In addition, if the facilitator notes that students are struggling and the scenario progression is compromised, the facilitator may wish to prompt students using verbal clues from the patient. For example, if students have not identified postoperative bleeding after a basic assessment, the patient may hint at the problem by saying, "Oh, I am so light-headed and I feel like my bed is all wet. Can you check to see if I wet the bed?" In many cases, these clues will be enough to redirect the scenario. If students remain at a total impasse, an alternative is to call a "time out," in which the facilitator pauses the scenario and talks with students about their perception of the situation and their plan of care. Following the time out, the facilitator may choose to begin the scenario from the beginning or continue with the scenario from the pause point.

The **Algorithm Quick Card** can be used as a guide to run a simulation scenario with or without using preprogrammed files. Any scenario can be run entirely *on-the-fly* (without preprogrammed files) using the **Algorithm Quick Card** as a reference, or scenarios may be run using preprogrammed files or "frames" corresponding to the initial settings, transition, and various possible outcomes. You can choose the method that works best for you. To create preprogrammed files for use in your simulation center, open the file programming feature in your particular simulator software and enter the data provided in the initial settings, transition, and outcomes boxes on the **Algorithm Quick Card**. Name the files accordingly and save them in a preprogrammed folder for use during the scenario.

On-the-Fly Guide

Human patient simulators can frustrate and perplex even the best facilitators. Learning to manipulate the computer, settings, transitions, and responses may appear daunting. To help with the complexities, the SLS includes the **On-the-Fly Guide** to help the facilitator set up the manikin in order to run the scenario. Once the manikin is set, the **Algorithm Quick Card** instructs the facilitator to modify the settings as the scenario progresses. In lieu of actual program files, the **On-the-Fly Guide** and scenario-specific algorithms allow the facilitator to make transitions and modifications as needed.

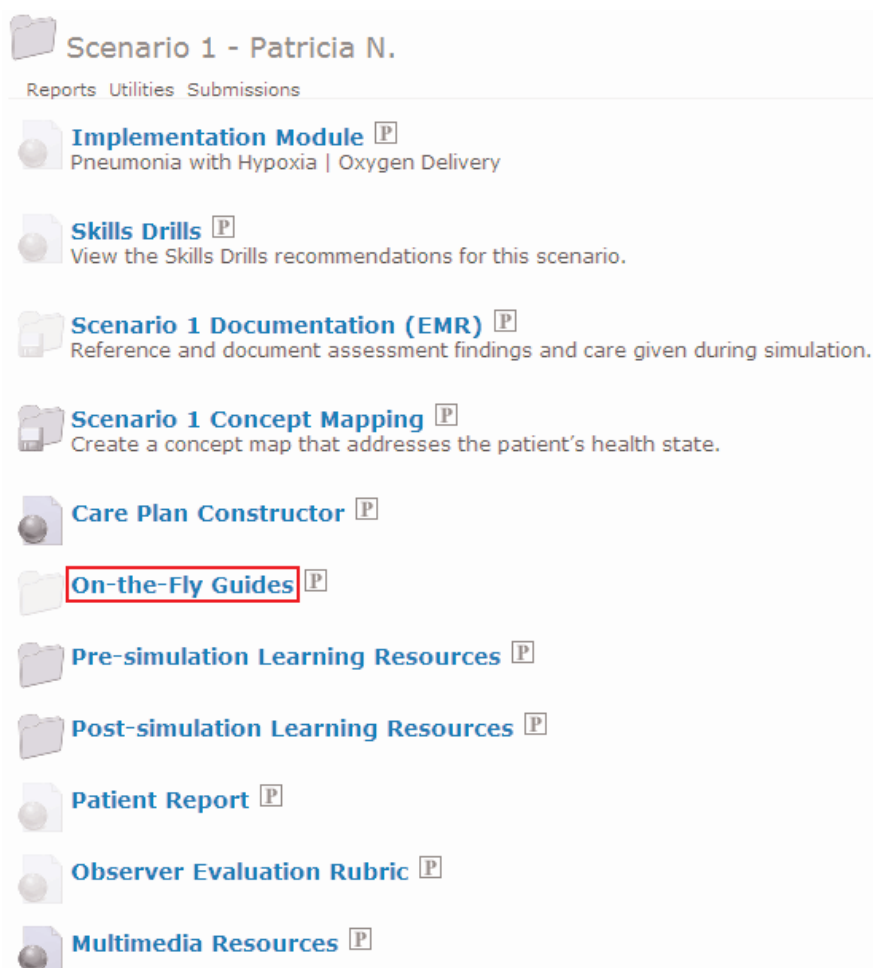
Any scenario can be run entirely on-the-fly using the **Algorithm Quick Card**. If you wish to save initial patient settings in order to implement a scenario quickly, directions are provided. You can choose the method that works best for you. Basic instructions are provided for running a scenario with or without the initial patient settings option.

The **On-the-Fly Guide** folder for each scenario can be found in the scenario's main menu.

Important Note:


If you are a Laerdal user, simply follow the sequencing on the **On-the-Fly Guide** and **Algorithm Quick Card** for the scenario you are running. **On-the-Fly Guides** are provided for both SimMan® and VitalSim®.


If you are a METI user, secure the appropriate **On-the-Fly Guide** and the **Algorithm Quick Card** for the scenario you are running.



Performance Checklist

Designed for the facilitator, the **Performance Checklist** details the expected student performance objectives specific to the scenario. The **Performance Checklist** is used for summative student evaluation following the simulation scenario. As the student progresses through the scenario, the facilitator can easily place a checkmark in the appropriate column—Exceeds Expectations, Meets Expectations, or Does Not Meet Expectations—and make comments.

	Performance Checklist		Student Name: <input type="text"/>	
Evaluation Rating			Performance Criteria	Comments
Exceeds Expectations	Meets Expectations	Does Not Meet Expectations		
Initial Assessment				
			Reviews patient's medical record.	
			Performs hand hygiene before and after patient contact.	
			Demonstrates appropriate use of personal protective equipment.	
			Introduces self to patient.	
			Verifies patient identity with two identifiers.	
			Facilitates informed consent for care by explaining interventions, rationales, and expected outcomes.	
			Conducts basic environmental safety assessment and maintains safety measures.	

The **Performance Checklist** is provided in the *Facilitator's Packet* and can be referenced in list format from anywhere within the **Implementation Module** by clicking on the icon  on the scenario header bar to the right of the scenario title.

The **Performance Checklist** should be shared with students during or after the debriefing session in order to facilitate student reflection and maximize learning. If the facilitator chooses, each performance behavior can be assigned a point value, and the checklist can easily be converted into a grading tool. For example, the student may earn a “2” if the performance exceeds expectations and a “1” if it meets expectations. The decision to use these scenarios as a grading tool or for competency testing should be made before the start of the scenario and identified in the course syllabus. Students should be informed of this during the clinical simulation orientation period.

Preparing Your Students

An important part of the student simulation experience is preparation. You can help your students maximize their time in simulation by assigning pre-simulation and post-simulation homework using the available scenario-specific resources. The Resources section of the **Implementation Module** lists all of the pre- and post-simulation learning resources that can be assigned. In addition to the scenario-specific assignments, the EMR User Guide should be assigned as reading before the first simulation scenario event, and should be continue to be accessible by students as a reference document throughout their simulation training.

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Preparing Your Students

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Facilitator Action

- Schedule a student group for simulation.
- Provide student access to the Pre-simulation Quiz and additional [Student Resources](#) as appropriate.
- Provide student access to the scenario-related [Skills Drills](#) or select your own from the [Skills Drills library](#).
 - The [SLS Implementation Guide](#) provides detailed instructions on enabling and disabling the student resources.
- Assign pre-simulation homework to the student group.
 - You might say: "Prior to your scheduled simulation period on Thursday at 2:00 PM, complete the Reading Assignment, Pre-simulation Exercises, and Pre-simulation Quiz for Scenario 1. Review the EMR to familiarize yourself with the patient's history. A change-of-shift report will be provided to you at the start of the simulation period."



◀ PREVIOUS NEXT ▶

To activate assignments, return to the main scenario folder and open the **Pre-simulation Learning Resources** and **Post-simulation Learning Resources** folders for the desired scenario. For detailed instructions on activating these resources, see the *Using Student, Faculty, and Evolve Resources* section of this guide, page 52.

You may elect to assign the student to review the patient's **EMR** prior to arriving at the simulation event. In this case, assign student access to the patient's **EMR** prior to simulation through the Post-simulation Learning Resources folder (see page 53). The student would review the **EMR** before patient care, just as might be done during an actual clinical assignment. The **EMR** contains data leading up to the scenario start time, but, like the pre-simulation activities, the **EMR** does not reveal any information about the patient's condition during the scenario, so reviewing the EMR would not “give away” the scenario.

Preparing the Setting

The **Preparing the Setting** section contains a reference copy of the scenario-specific Staging Instructions including equipment, props, medications, and facilitator's set-up actions. Please see detailed information about Staging Instructions in the *Facilitator's Packet* section of this guide on page 24.

2. SCENARIO

SCENARIO

- Initiating the Simulation Experience
- Scenario Phase I Introduction
- Scenario Phase II Experience
- Scenario Phase III Outcome

Initiating the Simulation Experience

Orientation. When students arrive on the first clinical simulation day, it is important to provide them with an orientation to the human patient simulator and its functionality, the equipment available in the room, and the surrounding environment. This should be individualized based on your setting and your students' familiarity with the simulation environment—students who are new to the simulator will need more time for orientation than more experienced students. Students should be given a clear idea of the general activities they will perform during any simulation. For example, they should be prepared to assume a role, receive report, review the *EMR*, and begin to provide care to the patient while following the steps of the nursing process.

Initiating the Simulation Experience			
Activity	Facilitator Action	Participant Action	Resources
Orientation	<ul style="list-style-type: none"> Describe setting. Describe simulation experience. Review simulator function. 	<ul style="list-style-type: none"> Complete permission to video consent. Orient to simulation environment. 	<ul style="list-style-type: none"> Simulator Operator's Manual SLS Implementation Guide Institutional protocol (if available)
Role assignment	<ul style="list-style-type: none"> Assign participant roles. 	<ul style="list-style-type: none"> Assume the role of the primary nurse, secondary nurse, patient's neighbor, and observer(s). 	<ul style="list-style-type: none"> Participant Role Badges Observer Evaluation Rubric Patient Response Guide Additional Participant Response Guide
Report	<ul style="list-style-type: none"> Provide report. 	<ul style="list-style-type: none"> Obtain report and collect essential patient care information. 	<ul style="list-style-type: none"> Patient Report

Certain ground rules should be established with students before beginning the clinical simulation experience. The facilitator should reinforce that the simulation environment is a safe and positive environment for students to practice their skills. It is essential to make students feel comfortable in simulation and acknowledge the possibility that they may make mistakes. Remind students that it is better to make a mistake in simulation and learn from the experience than to make a mistake with a real patient with the potential of causing harm. Take time to promote an environment that fosters constructive criticism and mature, respectful behavior. To establish an environment conducive to learning, make it clear that students must be respectful to their peers during and after the simulation experience and that there should be no ridiculing or demeaning of a peer who may have made an error. Students should understand that a debriefing session will be conducted following the scenario in which all participants will be given the opportunity to critically reflect on both the strengths and weaknesses of their performance as well as areas in which they can improve.

If written permission to film student performance is required in your simulation lab, permissions should be obtained during orientation.

Role Assignment. Following orientation, students should be assigned specific roles to be played during the simulation scenario. The facilitator may choose to assign student roles or allow students to randomly choose badges to determine their role. Each scenario includes the role of the primary nurse and secondary nurse, with some scenarios including additional participants such as a nursing assistant or a patient's family member or friend. In general, it is recommended that the role of the health care provider should be played by a facilitator or faculty member, as it is beyond a nursing student's scope of practice. As facilitator, you can include additional participants at your discretion, such as charge nurse, unlicensed assistive personnel, or lab technician. The inclusion of any assistive personnel allows the primary and secondary nurses to practice delegating tasks, while the delegate is given the opportunity to perform appropriate tasks and experience an ancillary role. The inclusion of students in roles such as friends or family members allows them to experience a health care setting from their unique perspective. Be sure to give participants in scripted roles the **Additional Participant Response Guide** for their role, available in the *Facilitator's Packet*.

The primary nurse is expected to act as the team leader during the scenario, with the secondary nurse assisting as needed within the nursing scope of practice. Participants in both nursing roles (primary and secondary) should be encouraged to talk and think out loud as they practice their clinical decision-making skills, while also being cognizant of their communication techniques.

To ensure that all roles are clearly identified during the scenario, have each student participant wear a badge. Printable **Participant Role Badges** are available in the *Facilitator's Packet*. You may also wish to provide costumes including wigs, hats, clothing, or other props for particular roles to enhance realism.

Report. To begin the simulation scenario, provide report using the **Patient Report**. Detailed information about using the **Patient Report** is found in the *Facilitator's Packet* section of this guide on page 28.

Scenario Phase I (Introduction)

The Scenario Phase I, II, and III screens provide detailed information about the scenario. This information is most useful if reviewed ahead of time by the simulation facilitator in order to understand the pathways of the scenario. It can be referenced as needed during the actual scenario. These documents provide a high level of detail in contrast to the **Algorithm Quick Card** which provides a visual overview of the scenario. If the facilitator is both controlling and speaking for the manikin, it is recommended that the **Patient Response Guide** and **Algorithm Quick Card** be printed for use at the control station, and that the Scenario Phase I, II, and III screens be kept close for occasional reference if needed.

Phase I represents the initial contact between student and patient. During this phase, the primary nurse enters the room, identifies the patient, and conducts a focused assessment. With each scenario, the additional events in Phase I are tailored to the specific scenario. The initial **Physiologic State**

indicates the specific physiologic parameters that should be programmed into the simulator. The **Situation/Transition** provides a description of the patient environment to be encountered by the student, along with a **Recommended Time to Advance** to the next phase. The time required to advance may vary based on actual student performance. The **Expected Student Performance** lists actions to be accomplished during the first phase of the scenario. These expected performance statements correspond with the **Performance Checklist**.

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Scenario Phase I: Introduction

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Start the scenario. Progress the patient situation following the [Algorithm Quick Card](#). Evaluate the student using the [Performance Checklist](#).

Physiologic State

T = 102.5 F (39.2 C)	• Heart sounds: Regular
BP = 148/82	• Lung sounds: Coarse
P = 116	• Abdominal sounds: Present
RR = 32	• Pulses: Normal
O ₂ Sat = 89% (room air; nasal cannula is disconnected from oxygen delivery device)	• Pain: 0/10
	• Patricia says, "It's a little hard to catch my breath. Where am I? I feel hot."

Situation/Transition

Patricia Newman has just returned from the pulmonary function lab and the transport team has settled her back in bed with the head of bed at 15 degrees. The nasal cannula tubing has not been correctly transferred to a functioning oxygen flow device, so she is not receiving supplemental oxygen. Patricia is intermittently confused and her vital signs reflect increased respiratory effort.

Recommended time to advance to Phase II: 5 minutes

Expected Student Performance

- Conducts initial and focused assessments.
- Recognizes abnormal findings:
 - Dyspnea
 - Decreased oxygen saturation level
 - Elevated respiratory rate
 - Confusion
 - Elevated temperature
- Recognizes findings as indication of inadequate oxygenation.

◀ PREVIOUS NEXT ▶

Scenario Phase II (Experience)

During Phase II, the student must use the data collected during the assessment process and begin to plan and intervene with the patient. Vital signs are included in each phase in the event that the student assesses vital signs at that time, not implying that students must assess vital signs during each phase. Depending on the assessment findings, the student may need to conduct interventions such as calling the appropriate health care provider and obtaining orders for treatments, administering medications, or performing other nursing interventions. Students will have the opportunity to implement nursing interventions and perform psychomotor skills, including—but not limited to—patient assessment, medication administration, intravenous fluid administration, oxygen initiation and monitoring, catheterization, and blood product administration, depending on the specific scenario. As in Phase I, the **Physiologic State**, **Situation/Transition**, **Recommended Time to Advance**, and **Expected Student Performance** are provided.

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Scenario Phase II: Experience

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Physiologic State

T = 102.5 F (39.2 C)
BP = 150/85
P = 124
RR = 36
O₂ Sat = 84% (room air; nasal cannula is disconnected from oxygen delivery device)

- Patricia says, "It's hard to breathe. (deep breath) Can you help me? I feel so hot and uncomfortable."

Situation/Transition

Until supplemental oxygen is reconnected, Patricia's oxygenation status worsens and she becomes confused and disoriented. She complains of feeling hot and uncomfortable because of her fever.

Recommended time to advance to Phase III: 5-10 minutes

Expected Student Performance

- Prioritizes respiratory interventions.
- Elevates head of bed.
- Recognizes and fixes disconnected oxygen tubing.
- Administers acetaminophen per order.
- Explains interventions.

PREVIOUS NEXT

Scenario Phase III (Outcome)

During Phase III, the simulator responds to the interventions (or lack thereof), in a positive or negative manner, resulting in the ultimate patient outcome. The student has the opportunity to reassess the patient and evaluate the effectiveness of the interventions. The **Physiologic State** and **Situation/Transition** are also provided as in previous phases. **Expected Student Performance** during Phase III involves evaluation of the interventions and documentation of the events in the **EMR**. Once the student completes all performance behaviors, or if the student appears to be following an incorrect pathway and the patient situation deteriorates, the facilitator may choose to state “The scenario is over” and proceed to the debriefing portion of the SLS.

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Scenario Phase III: Outcome

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Physiologic State

If supplemental oxygen is reconnected and acetaminophen is administered:

T = 102 F (38.9 C) BP = 148/82 P = 92 RR = 24 O₂ Sat = 92% (2 to 4 L/min via nasal cannula)	<ul style="list-style-type: none"> Patricia states, "Thank you."
---	---

If supplemental oxygen is reconnected but acetaminophen is NOT administered:

T = 102.6 F (39.2 C) BP = 148/82 P = 92 RR = 28 O₂ Sat = 92% (2 to 4 L/min via nasal cannula)	<ul style="list-style-type: none"> Patricia says, "I can catch my breath now. Is there anything you can do about this fever?"
---	--

If supplemental oxygen is NOT reconnected but acetaminophen is administered:

T = 102 F (38.9 C) BP = 156/88 P = 128 RR = 40 O₂ Sat = 74% (room air; nasal cannula is disconnected from oxygen delivery device)	<ul style="list-style-type: none"> Patricia states, "Leave me alone and let me catch my breath (deep breath)!"
---	---

If supplemental oxygen is NOT reconnected and acetaminophen is NOT administered:

T = 102.6 F (39.2 C) BP = 156/88 P = 128 RR = 40 O₂ Sat = 74% (room air; nasal cannula is disconnected from oxygen delivery device)	<ul style="list-style-type: none"> Patricia states, "I can't breathe (deep breath)! I feel terrible!"
---	--

Situation/Transition

If supplemental oxygen is reconnected, Patricia's respiratory status will improve. Vital signs will return to recent baseline.

If acetaminophen is administered, Patricia will express relief of discomfort and her temperature will begin to decrease.

If supplemental oxygen is not reconnected, Patricia will experience respiratory distress. Vital signs will reflect anxiety and inadequate oxygenation.

If acetaminophen is not administered, Patricia will continue to complain of fever-related discomfort and her temperature will remain elevated.

Expected Student Performance

1. Evaluates patient's response to interventions.
2. Provides emotional support to patient.
3. Documents all findings, interventions, and patient responses.

End the scenario.

◀ PREVIOUS NEXT ▶

3. DEBRIEFING

SIMULATION LEARNING SYSTEM

PNEUMONIA

Oxygen Delivery

PREPARATION ▼ SCENARIO ▼ **DEBRIEFING ▼** RESOURCES ▼

DEBRIEFING

- Debriefing Procedures
- Debriefing/Reflection Guide
- Guided Discussion: Questions
- Guided Discussion: Nursing Diagnosis
- Guided Discussion: Patient Teaching
- Guided Discussion: Growth and Development
- Guided Discussion: Culture and Diversity

Debriefing Procedure

A well-conducted debriefing session is integral to the simulation learning experience. The best debriefing experience allows participants to openly reflect on the scenario in a non-threatening and non-judgmental environment. The debriefing session should immediately follow completion of the scenario and should be conducted in a comfortable area with all scenario participants present. The facilitator's role in debriefing is to provide structure to the discussion as students actively review and discuss details and outcomes of the scenario. Facilitator's comments and reactions to student performance during the simulation should be kept to a minimum, and student participants should be encouraged to lead the discussion as much as possible. Reinforce the importance of the debriefing session and emphasize how this critical reflective process correlates with enhanced learning outcomes. The debriefing should last as long or longer than the scenario itself.

Debriefing Procedure

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Activity	Facilitator Action	Participant Action	Resources
Debriefing	<ul style="list-style-type: none"> • Allow students to discuss experience. • Discuss student performance. • Review Pre-simulation Exercises and lead Guided Discussion. • Provide remediation, if needed. • Assign Post-simulation Exercises and Post-simulation Quiz. • Activate Post-simulation Exercises and Post-simulation Quiz. • Assign any Skills Drills as needed. 	<ul style="list-style-type: none"> • Actively participate in a nonthreatening environment for reflective learning (self, group, and instructor) and constructive feedback. • Integrate prior nursing knowledge and skills. • Validate behavior, attitudes, and actions manifested during the simulation. • Model critical thinking and clinical decision making. 	<ul style="list-style-type: none"> • Observer Evaluation Rubric • Debriefing/Reflection Guide and Guided Discussion • Textbook: Lewis, et al: <i>Medical-Surgical Nursing: Assessment and Management of Clinical Problems</i> • Student Resources • Multimedia Resources • Skills Drills

◀ PREVIOUS NEXT ▶

Debriefing/Reflection Guide

The **Debriefing/Reflection Guide** is organized into 5 phases to help you provide structure to the debriefing process. The phases include:

1. Student Reaction
2. Student Reflection
3. Responsive Inquiry
4. Integration
5. Closure

The **Student Reaction** phase allows students to vent their feelings immediately after the scenario. During this phase, the facilitator invites students to share initial thoughts about the case. Students may experience intense emotional responses, especially if the patient suffered a negative outcome.

During the **Student Reflection** phase, students are encouraged to reflect on their decision making process and on interventions conducted during the scenario. During this phase, all participants should be encouraged to participate in the discussion. Observers should be encouraged to provide feedback using the **Observer Evaluation Rubric**.

During the **Responsive Inquiry** phase, the facilitator has several options for stimulating critical thinking and modeling clinical decision making for students. The **Performance Checklist** could be reviewed, including both positive feedback and honest evaluation of events that occurred during the scenario. If your simulation center has the capacity for recording the scenario, the recording can be reviewed with students at this time, allowing the facilitator to pause and ask critical thinking questions at pivotal points during the scenario.

During the **Integration** phase, discussion is guided to link theory to practice and facilitate transfer of knowledge to the clinical setting and next patient encounter. The Integration phase is also an optimal time to review any pre-simulation learning exercises that students completed before the simulation experience.

Other important clinical skills and concepts can be discussed during the **Responsive Inquiry** and **Integration** phases. The **Guided Discussion** section of the SLS (described below) provides suggestions for questions specific to the scenario. Other valuable debriefing topics common to all scenarios include therapeutic communication, professional communication, teamwork, patient safety, quality of care considerations, and documentation.

The **Closure** phase concludes the debriefing with the students' final thoughts on the scenario and positive, honest comments from the facilitator. If the scenario was particularly challenging for the students, the facilitator should be cautious not to offer false praise such as by saying, "Good job." Instead, the facilitator should offer an honest appraisal such as, "This was a difficult scenario and I appreciate your participation. It seems like this was a good learning experience."

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SCENARIO ▾


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Debriefing/Reflection Guide

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Debriefing is an integral part of every quality simulation. The best debriefing experience allows the students to discuss, digest, and discover. The facilitator's role in debriefing is to guide the discussion and to keep the conversation on topic. However, the facilitator's comments about the simulation should be kept to a minimum. The student participants should provide the majority of the discussion.



Phase 1: Student Reaction

Simulation experiences can be very emotional. The reaction phase allows the students to vent their feelings so that further discussion and learning can occur.

Examples of appropriate facilitator comments include:

- "Tell us about what you experienced during the simulation."
- "Please share some initial thoughts about the case."

Phase 2: Student Reflection

During the reflection phase, the facilitator asks the students to reflect on their decision-making process and on the actions taken during the simulation. Observers can comment using the Observer Evaluation Rubric.

Examples of appropriate facilitator comments include:

- "Describe your thought process as you made decisions about ____."
- "What patient response (or assessment) led you to ____?"
- "Did the patient respond the way you thought he/she would?"

Phase 3: Responsive Inquiry

Facilitators can use the Performance Checklist to identify and guide areas for inquiry.

Examples of appropriate facilitator comments include:

- "I noticed _____. What did you think about that?"
- "I am wondering why _____. Would you describe more about this?"

Phase 4: Integration

During the integration phase, the facilitator assists the students to apply theoretical content to the simulation as well as to anticipate the transfer of knowledge to the clinical setting.

Linking Theory to Practice:

- Use the debriefing questions designed for the specific scenario.

Assimilation:

- "How will this experience influence your patient care?"
- "What will you now do differently to prepare for clinical?"

Phase 5: Closure

With 1-2 minutes left, ask for any final thoughts on the scenario or the simulation experience. End with positive comments, such as:

- "I really appreciate how you ____."
- "It seems like this was a really good learning experience."
- "I really appreciate everyone's participation."

Developed by Deborah Bambini, PhD, RN, WHNP, CNE and Kristin Ulstad, MN, RN, CCTN

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Guided Discussion: Questions

The SLS provides questions that directly relate to the scenario content for guided discussion during the Responsive Inquiry and Integration phases of debriefing. These questions cover topics such as pathophysiology, treatment options, expected patient responses to interventions, quality and safety indicators, and protocols. Suggested answers, rationales from the textbook, reading assignments, and multimedia resources are provided to assist facilitators in leading discussion and initiating remediation. Encourage students to openly share their responses to these questions during the debriefing session. If students are challenged by a question, encourage them to think out loud and collaborate with their peers to problem-solve and arrive at the best answer.

Alternatively, if debriefing time is limited, the guided discussion questions may be utilized as a large group discussion in a lecture class shortly after the simulation event, or assigned as homework immediately following simulation.

Guided Discussion: Nursing Diagnosis

Corresponding North American Nursing Diagnosis Association (NANDA) International-approved nursing diagnoses and patient goals from your specific nursing textbook are provided for each scenario, with page references included. The facilitator may use these diagnoses as a guide when asking students to identify appropriate scenario-specific nursing diagnoses and to develop related patient goals. Suggested answers are provided to the facilitator to assist in leading the discussion.

PREPARATION SCENARIO DEBRIEFING RESOURCES

Guided Discussion: Questions

◀ PREVIOUS Screen 13 of 19 NEXT ▶

Click each question to view its possible answers, rationale, and remediation resources. These will be displayed below the list of questions.

1. What are the early signs and symptoms of inadequate oxygenation?

Possible Answers

- Unexplained apprehension
- Unexplained restlessness or irritability
- Unexplained confusion or lethargy
- Tachypnea
- Dyspnea on exertion
- Tachycardia
- Mild hypertension
- Dysrhythmias (e.g., premature ventricular contractions)
- Diaphoresis
- Decreased urinary output
- Unexplained fatigue

Rationale

p. 515: The ability of the lungs to oxygenate arterial blood adequately is determined by examination of the partial pressure of oxygen in arterial blood (PaO₂) and arterial oxygen saturation (SaO₂).

Remediation Reading Assignment

"Physiology of Respiration," pp. 500-502
 "Assessment of Respiratory System," pp. 504-512

Multimedia Resources

Patterns of Respiration

Respiration, Internal: Tissue Oxygenation

2. Is maintaining oxygen saturation greater than 88% adequate for this patient? Give a rationale for your answer.
3. What type of pneumonia does this patient have?
4. What has predisposed this patient to pneumonia?
5. What diagnostic studies assist in diagnosing pneumonia in this patient?
6. Are any of Patricia Newman's diagnostic study values abnormal? If so, why?
7. According to the AHRQ Pneumonia Patient Outcomes Research Team Severity Index, what level of risk is this patient?
8. What priority nursing interventions should be implemented for the management of this patient?
9. What interventions might help this patient once the acute episode of pneumonia has resolved?

◀ PREVIOUS NEXT ▶

PREPARATION SCENARIO DEBRIEFING RESOURCES

Guided Discussion: Nursing Diagnosis

◀ PREVIOUS Screen 14 of 19 NEXT ▶

1. Ineffective breathing pattern related to inflammation and pain as evidenced by dyspnea, tachypnea, nasal flaring, altered chest excursion

Goal

- The patient will demonstrate an effective respiratory rate, rhythm, and depth of respirations.

Textbook reference: p. 552

2. Ineffective airway clearance related to retained secretions and excessive mucus as evidenced by ineffective cough, adventitious breath sounds, dyspnea

Goal

- The patient will demonstrate effective coughing and increased air exchange.
- The patient will experience normal breath sounds.

Textbook reference: p. 627

3. Impaired gas exchange related to alveolar hypoventilation as evidenced by PaCO₂ > 45 mm Hg, PaO₂ < 60 mm Hg, or O₂ Sat < 90% at rest

Goal

- The patient will return to baseline respiratory function.
- The patient's PaCO₂ and PaO₂ will return to levels normal for patient.

Textbook reference: p. 627

◀ PREVIOUS NEXT ▶

Guided Discussion: Patient Teaching

Patient teaching points related to each scenario are included with corresponding textbook references. The facilitator can refer students to these textbook references for remediation and guidance if needed.

PREPARATION ▼

SCENARIO ▼

DEBRIEFING ▼

RESOURCES ▼

Guided Discussion: Patient Teaching

◀ PREVIOUS Screen 15 of 19 NEXT ▶

- Smoking cessation**

Key Points

 - Smoking is a risk factor for developing chronic obstructive pulmonary disease (COPD).
 - Smoking influences the respiratory system and changes the anatomical structure and function of the airway and lungs.
 - Smoking cessation is the most effective way to reduce the development of COPD and stop the progression of the disease.
 - The sooner smoking stops, the sooner symptoms decrease.

Textbook reference: pp. 610-611, 617
- Pursed-lip breathing**

Key Points

 - Pursed-lip breathing assists in prolonging exhalation and prevents bronchiolar collapse and air trapping.
 - The patient should be taught this technique and use before, during, and after any activity that causes dyspnea.

Textbook reference: p. 623

◀ PREVIOUS NEXT ▶

Guided Discussion: Growth and Development

Students are encouraged to consider how the patient's condition may impact social interactions, family dynamics, and role performance. In this section, growth and development considerations, including Erikson's stages specific to each patient, are presented with corresponding textbook references.

PREPARATION ▼

SCENARIO ▼

DEBRIEFING ▼

RESOURCES ▼

Guided Discussion: Growth and Development

◀ PREVIOUS Screen 16 of 19 NEXT ▶

- Developmental Stage**
 Middle adulthood (age 35-65)
 Erikson developmental stage: Generativity vs. self-absorption and stagnation

Key Points

 - Time of critical self-review
 - Sense of productivity and creativity; reaching established goals (generativity)
 - Lack of accomplishment; self-absorption (stagnation)
 - Ability to expand personal and social involvement
 - Accepting and adjusting to the physiological changes of middle age
 - Health promotion
 - Career transition
 - Adjusting to aging parents; "sandwich generation"
 - Willingness to care for and guide others
- Gerontologic Considerations**
 Pneumonia and the older adult

Key Points

 - Pneumonia is a leading cause of death in older adults. Older adults are predisposed to pneumonia because of a diminished immune response, environmental factors, and anatomical structural changes.
 - Hypoxia may not produce the normal compensatory mechanisms (increased pulse, increased stroke volume, increased cardiac output) as seen in the young
 - Slower response to oxygen therapy
 - Physiological changes:
 - Diminished cough reflex
 - Decreased number and activity of cilia
 - Decreased production of surfactant
 - Thickening of the alveolar-capillary membrane
 - Increase in anterior-posterior diameter of chest wall
 - Increase in functional residual capacity
 - Increase in residual volume
 - Decrease in tidal volume
 - Decrease in vital capacity
 - Decrease in forced expiratory volume
 - Breath sounds distant if kyphosis present

References

Edelman and Mandle: *Health Promotion Throughout the Life Span*, 7th Edition, St. Louis, 2010, Mosby

Potter and Perry: *Fundamentals of Nursing*, 7th Edition, St. Louis, 2009, Mosby

◀ PREVIOUS NEXT ▶

Guided Discussion: Culture and Diversity

Culture and diversity considerations are presented for each scenario with textbook references.

PREPARATION ▼

SCENARIO ▼

DEBRIEFING ▼

RESOURCES ▼

Guided Discussion: Culture and Diversity

◀ PREVIOUS Screen 17 of 19 NEXT ▶

- Cultural risk factors for pneumonia**

Key Points

 - COPD is more common in men than in women.
 - Number of women with COPD is increasing.
 - Cigarette smoking is the major risk factor of COPD (emphysema).
 - Prevalence of smoking is higher among African Americans, blue-collar workers, and less educated individuals.
 - Smoking prevalence is highest among Northern Plains American Indians/Native Americans and Alaskan Natives.
 - Pneumonia is the fifth leading cause of death for Chinese Americans.
 - Alaskan Natives and Native Americans are at a higher risk for developing pneumonia.
 - Death rates related to COPD for Hispanics are significantly lower than for other ethnic groups.
 - Persons of northern European descent are more affected by genetic AAT deficiency, a factor leading to COPD.

Textbook reference: pp. 610-611

References

Giger and Davidhizar: *Transcultural Nursing: Assessment and Intervention*, 5th Edition, St. Louis, 2008, Mosby

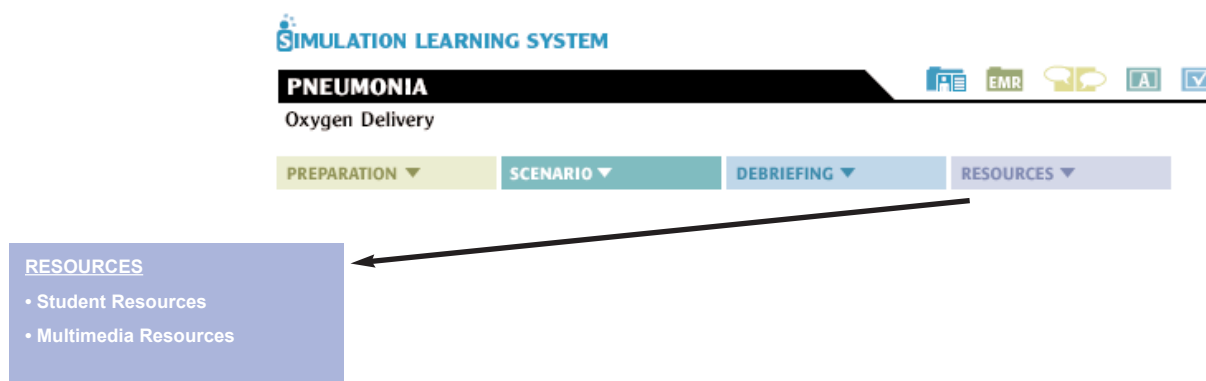
Potter and Perry: *Fundamentals of Nursing*, 7th Edition, St. Louis, 2009, Mosby

◀ PREVIOUS NEXT ▶

Debriefing—Final Notes

Students should be reminded that the details of the particular simulation scenario should not be shared with other nursing students—this ensures that all students are given equal opportunity to experience clinical simulation and that no student will have an unfair advantage. In addition, if your institution records the simulation scenarios for student review during the debriefing session, students should sign a permission form indicating that the recording will be used only for educational purposes, will not be shared with individuals who have not been directly involved with the simulation scenario, and will be destroyed following review. You may wish to include specific institutional policies and procedures that guide the process of data recording, management, and storage.

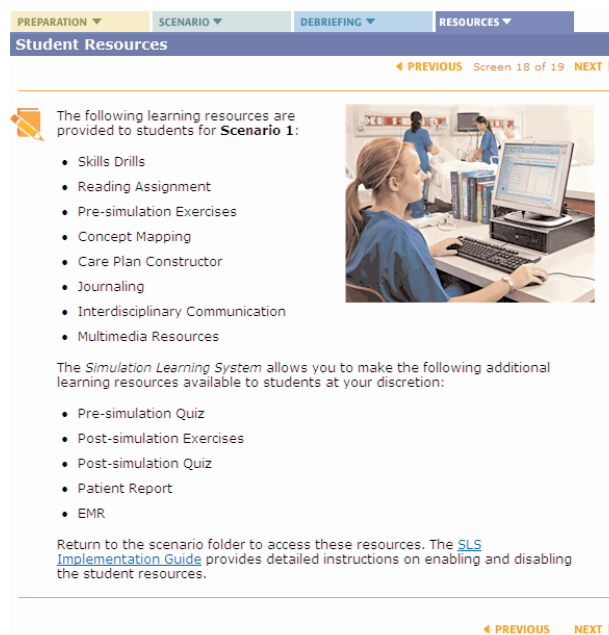
4. RESOURCES



Student Resources

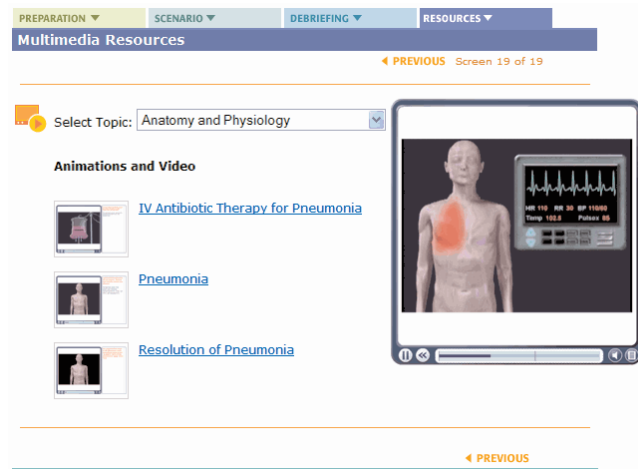
Numerous scenario-specific resources are available for student learning and evaluation before and after simulation. The *Student Resources* screen summarizes these resources for each scenario.

For detailed instructions on activating these resources, see the *Using Student, Faculty, and Evolve Resources* section of this guide, page 52.



Multimedia Resources

The SLS is embedded with numerous multimedia resources that correlate to the scenario or to the type of patient represented to further enhance understanding of the nursing concepts. Animations, skills videos, and audio clips offer review of physiologic processes and nursing procedures and are available to students for reference and review before or following simulation, although access can be restricted at your discretion.



Electronic Medical Record

The nurse's effective use of an **EMR** is directly related to improved patient outcomes in the health care setting. Nursing students must be able to access, retrieve, and interpret health-related information effectively in order to provide safe, optimal care to their patients. When reviewing a patient's record, nursing students must gather and interpret the pertinent data while sorting through the voluminous amount of information provided.

The SLS provides an opportunity for students to learn these skills through the use of a fully functional **EMR** for each simulation scenario. The **EMR** allows students to reference important patient data and document assessment findings and care given during simulation using forms and methods similar to those they will use in both the clinical setting and in practice. The **EMR** should be accessible in or near the patient's room during simulation.

To launch the **EMR**, the student logs into their own *Evolve* account. Any modifications made to the **EMR** under a student's login will be saved only to that student's account. Student **EMR** documentation during the scenario can be saved and retrieved later by the student for further charting and electronic submission to the instructor, or documentation can be submitted immediately after the scenario for evaluation. Students should reference the *EMR User Guide* in their SLS *Evolve* account for specific instructions about how to use the **EMR**, how to submit documentation to their instructor, and how to access **EMR** support if needed.

Although particular aspects of the **EMR** may or may not be relevant to the scenario, all sections of a basic patient chart are included for each scenario to closely mirror a real patient chart. The facilitator can use any parts of the **EMR** to reinforce other pertinent clinical concepts in debriefing or individually with students as time allows. As in the real clinical setting, portions of the **EMR** may have data omissions, giving the student the opportunity to discover the missing data and interpret the consequences of the omissions. Each section of the **EMR** is described in detail below.

IDENTIFICATION

The **Identification** page appears first in the *EMR*. The patient's medical record number, name, room number, gender, age, provider's name, primary diagnosis, secondary diagnosis, allergies, height, weight, and code status are listed next to a photograph of the patient. These data cannot be modified by the student. Using this information, students should correctly identify the patient and validate the presented information with the simulated patient, especially related to patient allergies.

SIMULATION LEARNING SYSTEM

Save Download Submit Restart Log off

HRN: 1868097 Room: 406 Age: 61 Provider: Joseph Molina, MD Code Status: Full code


Patient: Patricia Newman Gender: Female Weight: 100 lb Allergies: x

Identification

HRN: 1868097
 Patient Name: Patricia Newman
 Room: 406
 Gender: Female
 Age: 61
 Provider Name: Joseph Molina, MD
 Primary Diagnosis: Pneumonia
 Secondary Diagnosis: Emphysema
 Allergies: No known allergies
 Height: 5 ft 5 in
 Weight (at admission): 100 lb
 Code Status: Full code

User: Danny Witzofsky (witzofsky) | Scenario Newman 1 | Sim Day/Time: Tue at 1630 | © Elsevier. All rights reserved.

NURSING FLOW SHEETS

The interactive **Nursing Flow Sheets** section of the *EMR* contains nursing assessment and intervention data beginning at the time of the patient's admission to the inpatient unit. The flow sheets are organized according to the following subcategories: *Vital Signs*, *Pain*, *Intake & Output*, *IV Therapy*, *Special Monitoring*, *System Assessment*, *Safety & Hygiene*, and *Restraints*. Students can document assessments they have conducted during the scenario, gaining practice that will lead to improved documentation skills transferrable to the clinical setting. Codes for abbreviations are listed under the information icon  to the left of each assessment item. Each subcategory within the **Nursing Flow Sheet** section is described in detail below.

SIMULATION LEARNING SYSTEM

Save Download Submit Restart Log off

HRN: 1868097 Room: 406 Age: 61 Provider: Joseph Molina, MD Code Status: Full code

Patient: Patricia Newman Gender: Female Weight: 100 lb Allergies: x

Flow Sheets

Vital Signs Pain Intake & Output IV Therapy Special Monitoring System Assessment Safety & Hygiene Restraints

DAY/TIME Day Tue 1300 Tue 1330 Tue 1350 Tue 1430

Vital Signs

Assessment	Tue 1300	Tue 1330	Tue 1350	Tue 1430
TEMPERATURE (F)			101.2	
TEMPERATURE (C)			38.4	
TEMPERATURE MODE OF MEASUREMENT			Ty	
SYSTOLIC BLOOD PRESSURE			148	150
DIASTOLIC BLOOD PRESSURE			82	84
BP MODE OF MEASUREMENT			NIBP	NIBP
HEART RATE			106	118

User: Danny Witzofsky (witzofsky) | Scenario Newman 1 | Sim Day/Time: Tue at 1630 | © Elsevier. All rights reserved.

Vital Signs. This interactive page contains information regarding the patient's temperature, blood pressure, pulse, respirations, oxygen saturation, blood glucose, height, and weight, as well as other vital measurements. These fields will be populated up to the time of the scenario start according to the patient's hospital stay. Students should reference this page to determine the patient's baseline vital signs, detect trends in the values, and document findings noted as part of the care administered during the simulation scenario.

Pain. This interactive page contains information regarding the patient's report of pain according to the pain rating scale, the location, characteristics, and relieving factors. Students should use the appropriate pain scale to evaluate the patient's pain and to determine trends related to pain management. In addition, students can enter their own assessment findings in this section.

Intake & Output. This interactive page represents the patient's fluid intake and output since admission. Depending on the course of the simulation scenario, the student can enter the specific fluid intake (either by IV or by mouth) and output (such as urine, blood, emesis, nasogastric tube secretion, or liquid stool) obtained while caring for the simulated patient. Additional learning activities using this record may include determining a trend related to intake and output values since the patient was admitted and using these data to determine the patient's fluid balance status.

Intravenous Therapy. Information about intravenous therapy is recorded on this page. The IV fluids and rates of administration can be documented by students.

Special Monitoring. Information related to PCA Pump Monitoring can be found within this tab.

System Assessment. This tab is organized according to biological and psychosocial systems: Respiratory, Cardiovascular, Neurologic, Gastrointestinal, Genitourinary/Reproductive, Musculoskeletal, Integumentary, and Psychosocial. Any assessments completed during simulation should be documented in this section by the student. Student learning activities using assessment data include identifying abnormal findings or trends in assessments.

Safety & Hygiene. Patient safety is paramount in any clinical setting. Students must document the fall risk and basic safety measures implemented. This interactive page also details interventions related to patient hygiene and comfort.

Restraints. For simulated patients who have restraints ordered, students should use this interactive flow sheet to document the restrained patient's care. Students should ensure that the patient has the restraints removed at appropriate intervals and has been offered nutrition and toileting; that alternative clinical activities have been offered; and that the neurovascular status of the restrained area has been documented. Rules and regulations regarding the use of restraints in the clinical setting and the impact of restraints on patient's rights are continually changing; the *EMR* reflects the current practice recommendations at time of publication. Suggested learning activities include asking students the rationale for these changing regulations and how proper documentation can ensure that the rights of restrained patients are protected.

MEDICATION RECORDS

In this interactive portion of the EMR, students can review medications administered since the patient's admission and document all medications administered during the simulation scenario. Medication administration errors are among the most common preventable medical errors. The Medication Records allow students to practice the skill of proper medication administration, which will enhance patient safety in the clinical setting. The student can carefully reference medication orders, check for medication allergies, and practice implementing the six rights of safe medication administration in the simulated clinical setting. Practicing in the simulation lab will enhance student performance of these important skills.

DATE	MEDICATION	TIME
Tue 1330	Dextrose 5% in 1/2 normal saline with potassium chloride 40 mEq/L at 75 mL/hr	0000 HA
	IV Continuous infusion	
Tue 0800	Dextrose 5% in 1/2 normal saline with potassium chloride 20 mEq/L at 75 mL/hr	0000 HA
	IV Continuous infusion	
	Discontinue: Tue 1300	
Tue 0800	Ipratropium metered-dose inhaler 2 puffs	0000 HA
	3 times daily	2000 HA
Tue 0800	Calcium carbonate 600 mg	0000 HA
	PO, mouth	2000 HA

Only medications ordered and administered before the start of the scenario will be included in the Medication Records. During the course of the scenario, if a new medication is ordered or administered, students can enter the medication order in the Orders and the Medication Records section and document that the medication was administered. Once the medication is administered, the time appears as a strikethrough in the record. The facilitator can use the Medication Records list to facilitate discussion of the classification, mechanism of action, and nursing considerations related to the medications, in addition to asking the student to provide the rationale for the medication order.

NURSES' NOTES

This portion of the **EMR** contains the narrative nursing notes, which begin at the time of patient admission. Any information that cannot be adequately described in the nursing flow sheet should be documented in narrative format in the **Nurses' Notes** to supplement the flow sheets. Students can add their narrative documentation of the events that occurred during the simulation scenario, such as detailed assessments, patient interventions, and the patient response to the particular intervention. The facilitator should instruct students to write detailed nursing notes regarding the simulated patient experience. Thorough documentation of clinical events is essential to the safe care of patients in the clinical environment—a skill that can be practiced in the **EMR** during clinical simulation.

ORDERS

The primary health care provider's written orders are documented in the **Orders** section. These orders begin at the time of admission and progress until the scenario begins. Checking and interpreting orders correctly is a valuable nursing skill that ensures patient safety. The facilitator should make sure that students access this information when checking medication orders in the **Medication Records** and when implementing any nursing or medical interventions. If the student obtains any verbal orders during the course of the simulation scenario, these orders can be documented on this interactive page.

PHYSICIAN'S PROGRESS NOTES

Physician notes or primary health care providers' notes are displayed under the **Physician's Progress Notes** tab. These narrative notes include the primary health care provider's description of the patient assessment along with the rationales for interventions. This information cannot be modified by the student. Suggested learning activities include the analysis of this information when determining the rationale for various orders, such as medication changes, treatment additions, or the ordering of diagnostic tests.

LABORATORY REPORTS

Results of blood, urine, wounds, fluids, or any other lab results from the time of the patient's admission will be found in the **Laboratory Reports** section of the *EMR*. By scrolling over the information icon to the left of the term, a pop-up box will reveal expected reference values.

Laboratory reports and studies requested during the simulation scenario will not be found in the **Laboratory Reports** section because the *EMR* only reflects the time leading up to the clinical simulation experience. Laboratory results which are reported during the simulation scenario can be communicated by the facilitator verbally via a telephone call to the primary nurse, or in a printed or projected laboratory result format.

The facilitator can reinforce the interpretation of patient laboratory report data before, during, or after the simulation scenario to enhance student understanding of how results relate to the care of the patient. The facilitator may ask students to report normal ranges for laboratory values and give suggested rationales for abnormal findings.

DAY/TIME	Tue 1230	Tue 1000	Tue 0500
HEMATOLOGY			
y Red Blood Cell Count	4.5	4.5	
y Hemoglobin	14.9	15	
y Hematocrit	44	45	
y Mean Corpuscular Volume	89	90	
y Mean Corpuscular Hemoglobin	28	29	
y Mean Corpuscular Hemoglobin Concentration	34	35	
y Red Blood Cell Distribution (RDW)	13	13	
y White Blood Cell Count	15,500	16,000	
y DIFF: Neutrophil Segs	5883	6080	
y DIFF: Neutrophil Bands	4134	4000	

DIAGNOSTIC REPORTS

Results of radiologic tests and other special diagnostic studies can be found under the **Diagnostic Reports** tab. Types of studies include chest x-rays, magnetic resonance imaging, and computerized tomography scans. Diagnostic reports cannot be modified by the student. Diagnostic reports requested during the clinical simulation experience will not be found here because the *EMR* only reflects the time leading up to the clinical simulation experience. If, for instance, a stat ultrasound is requested during the course of the simulation scenario, the facilitator should report the results verbally via telephone to the primary nurse, or present the primary nurse with a printed or projected ultrasound results report. The facilitator may wish to use the contents of the **Diagnostic Reports** section as a tool to review with students the nursing care of the patient before and after a procedure. The **Diagnostic Reports** also allow the facilitator the opportunity to discuss actual test results related to the patient's diagnosis, and explore implications for patient care with the students.

Radiology Diagnostic Report

Name: Alice Morrison MRN: 7791622
Age: 7 years Room: 508
Sex: Female
Physician: Carlos Gonzalez, MD

Department: Radiology
Type of Exam: Anterior/posterior chest x-ray
Day of Exam: Saturday 0645
Report: Supine film shows right upper lobe opacity with mild atelectasis. Right and left lower lobes exhibit mild atelectasis. Cardiac size within normal limits for age and weight. Narrowing in the distal trachea.

Impression: Right upper lobe infiltrates

CONSULTS/PROCEDURES

If the simulated patient was assessed by a specialist, such as a cardiologist, nutritionist, or social worker, a report of the visit is located in the **Consults/Procedures** tab. This section cannot be modified by the student. The facilitator may use this information to discuss with students the potential patient implications and nursing interventions related to the specific consult.

Wound/Ostomy Care Consult - Page 1

SLS

WOUND/OSTOMY CARE CONSULT NOTE

Name: Jesus Garcia MRN: 7738876
Age: 28 Room: 313
Sex: Male
Physician: Michael Levin, MD

Consultation Type: Wound/ostomy care
Day: Wed
Time: 0745
Reason for Consultation: 15 days post temporary loop colostomy
Referral Source: Michael Levin, MD

History of Present Illness
Patient is a 28-year-old Hispanic male who presented for direct admission to hospital after experiencing nausea and decreased oral intake for the past 5 days. Patient has a long history of moderate left-sided colitis, unresponsive to medical therapy. He underwent elective colectomy and transverse loop colostomy 15 days ago and was discharged home 5 days ago. He received TPN postoperatively for lower rest but now presents with nausea, vomiting, and weakness. Denies any blood in colostomy bag. States that stool has consisted of a large amount of effluent with some semiformal material.

Ostomy location
Left upper quadrant, just left of midline abdomen

Wound/Ostomy Care Consult - Page 1

User: Danny Wilosky (dwilosky) | Scenario: B | Sim Day/Time: Thur at 1600

HISTORY AND PHYSICAL

The **History and Physical** tab contains the initial history and physical (H&P) report. Subsections of this comprehensive form include the following: *Chief Informant, Chief Complaint, History of Present Illness, Allergies, Family History, Past Medical History, Social History, Current Medications, Immunizations, Review of Systems, Physical Exam, Impressions, and Plan.* The history and physical is completed by the primary health care provider when the patient is admitted; therefore, this information cannot be modified by the student. With the history and physical data serving as the foundation for admission orders, the facilitator can ask the student to provide a rationale for the admitting orders based on the H&P. The facilitator may also ask the student to identify any abnormal findings in the report and relate these to the diagnosis and care of the simulated patient.

SIMULATION LEARNING SYSTEM

MRN: 1868097 Room: 406 Age: 61 Provider: Joseph Molina, MD
Patient: Patricia Newman Gender: Female Weight: 100 lb Allergies: Full screen

History and Physical

Chief Informant: Patient
Chief Complaint: "I think I have pneumonia again."
History of Present Illness: Patient, a 61-year-old female, presented to the emergency department this morning with dyspnea at rest and productive cough and fever for past day and a half.
Allergies: None known
Family History: Adult children healthy. Mother deceased at age 63, heart attack; father deceased at age 59, stroke.
Past Medical History: Previous Illnesses: Emphysema for 12 years, multiple hospitalizations for pneumonia in the past 2 years, 8-year history of osteoporosis, 15-year history of hypertension
Contagious Diseases: None
Injuries or Trauma: No significant history
Surgical History: Hysterectomy
Dietary History: Poor, per patient report
Other: Smoker, 90-pack-year history; gravida 2 para 2, no complications

NURSING ADMISSION

The **Nursing Admission** section is completed by the nurse at the time of the patient's admission to the inpatient unit. Whether or not students will complete this section themselves depends on when the simulation is scheduled to occur during the course of the hospitalization. That is, if completion of the admission assessment section is a stated performance objective for the clinical simulation scenario, students will be able to enter data. However, if the patient was admitted before the designated simulation scenario start time, the section will have been previously completed and students will not be able to modify the existing data. Subsections of this comprehensive nursing form include the following: *Patient Profile, Health Promotion, Nutrition/Metabolic, Elimination, Activity/Rest, Perception and Cognition, Self-Perception, Role Relationships, Sexuality, Coping and Stress Tolerance, Life Principles, Safety/Protection, Comfort/Pain, and Growth and Development.* These categories provide data necessary for students to provide holistic care to the simulated patient. Students can use this information to create pertinent nursing diagnoses and a comprehensive plan of care for their patients.

SIMULATION LEARNING SYSTEM

MRN: 1868097 Room: 406 Age: 61 Provider: Joseph Molina, MD
Patient: Patricia Newman Gender: Female Weight: 100 lb Allergies: Full screen

Nursing Admission

Adult Profile | Health Promotion | Nutrition/Metabolic | Elimination | Activity/Rest | Perception and Cognition | Self-Perception | Role Relationships | Sexuality | Coping and Stress Tolerance | Life Principles | Safety/Protection | Comfort/Pain | Growth and Development

ADULT PROFILE

How to be addressed: Patricia
Admission date: Tuesday
Reason for this admission as stated by patient/chief complaint: "I think I have pneumonia again."
Diagnosis: Pneumonia, emphysema

Allergies and reactions

Drugs: None
Food: None
Other: None

Armband name verified: Yes
Patient instructed in the use of: ☒ Cell light ☒ Bed rails
☒ Smoking policies ☒ Visiting hours

Date of birth: June 6 (age 61)
Gender: ☐ Male ☒ Female
T (°F): 101.1
Blood pressure (systolic/diastolic): 162/90
Pulse: 108

SURGICAL REPORTS

Surgical Reports are included in the **EMR** if the simulated patient underwent a surgical procedure. Reports include the following: *Anesthesia Questionnaire, Operative Report, PACU Discharge, Preoperative Checklist, Preoperative Patient Instruction, and Surgery Unit Admission Form*. This portion of the **EMR** cannot be modified by the student. The facilitator can use this information to reinforce operative content such as the preoperative assessment, consent for treatment, preoperative checklist, and important legal implications related to operative consents.

The screenshot shows the 'Intraoperative Record - Page 1' form. It includes patient information (Name: Lillian Chambers, Age: 40, Sex: Female, Physician: Rhonda Spratt, MD), date (Friday), time (0900), and various clinical details like 'To OR By Way Of: Stretcher', 'To OR From: Medical Surgical Unit', and 'Transfer By: Gretchen Lucas'. It also lists 'Patient Identifications: Time Out and Double Identifiers', 'Allergies and Reaction: NKA', 'Milestone: GS', and 'Mental/Emotional Status: Alert and oriented, Anxious but cooperative and calm.' The 'Preoperative Antibiotic Documented' section shows 'Piperacillin/tazobactam 4.5 g IV at 0800 KL'.

EMERGENCY DEPARTMENT

Data will be found in the **Emergency Department** record if the simulated patient experienced an emergency department (ED) visit during the current admission. This multidisciplinary documentation form contains the following subsections: *Patient Demographics, Chief Complaint, Initial Assessment, Systems Review, Medication Record, Laboratory Record, Radiology Record, Nurse's Notes, and Provider's Progress Notes*. If the simulation scenario takes place in the emergency department, the student will be able to enter data in this form to reflect care administered. The facilitator can discuss how this ED record differs from documentation used on the clinical unit and why these differences exist. For example, by accessing this form, students will be able to see how the care of the patient in the emergency department is focused on quickly diagnosing and stabilizing the patient and then preparing for transfer to the appropriate clinical area.

The screenshot shows the 'Emergency Department' form for patient Patricia Newman. It includes patient demographics (Age: 61, Gender: Female, Weight: 100 lb), arrival date/time (Tues 0100), and chief complaint ('I think I have pneumonia again'). The 'Initial Assessment' section describes the patient as a 61-year-old female in moderate respiratory distress. The 'Medication History' table lists medications like Calcium carbonate, Estradiol patch, Hydrochlorothiazide, and Metoprolol. The 'Allergies' section shows 'None known'.

PATIENT EDUCATION

Patient education is a priority of nursing care in the clinical setting. The **Patient Education** tab includes patient goals and a form outlining a systematic process for documenting educational interventions and progress toward meeting the goals. A concise method of coding is used to assist with the documentation on the form. As students provide patient teaching, the interventions can be documented and modified in the **Patient Education** section. As with all other sections where students enter documentation data, the facilitator can review and offer constructive feedback to students regarding patient education. In addition, patient teaching topics are covered in the debriefing guide following the scenario. The facilitator may ask the student to provide a rationale for certain patient education topics or create a sample teaching plan including methods of delivery and expected patient outcomes.

The screenshot shows the 'Patient Education' form for patient Patricia Newman. It includes a list of educational goals (e.g., 'Patient will demonstrate correct use of metered-dose inhaler') and a table for documenting teaching interventions. The table has columns for Goal #, Item Taught, Person Taught, Current Teaching Day, Level, and Initial Teaching Day, Level, and Int.

DEMOGRAPHICS

The **Demographics** section contains admission information including admitting diagnoses, patient address and telephone number, emergency contact, insurance details, admission consent, and information about whether or not the patient has an advanced directive. This information cannot be modified by the student. Suggested learning activities may include asking the student to review the patient's insurance information to anticipate any limitations or challenges for patient care access after discharge.

Simulation Learning System

MRN: 1668007 Room: 406 Age: 61 Physician: Joseph Molina, MD
 Patient: Patricia Newman Gender: Female Weight: 100 lb Allergies: [None]

Demographics

Page 1 | Page 2 | Page 3

Authority for Admission

Name: Patricia Newman MRN: 1668007
 Age: 61 Room: 406
 Sex: Female
 Physician: Joseph Molina, MD

Admission Date	Discharge Date	Diagnosis 1	Diagnosis 2	Diagnosis 3	Diagnosis 4	Diagnosis 5
Admission Date: 0803	Discharge Date: 0803	Diagnosis 1: Pneumonia	Diagnosis 2: N/A	Diagnosis 3: N/A	Diagnosis 4: N/A	Diagnosis 5: N/A

Admission Service: PULM
 Scheduled Procedure No. 1: N/A
 Scheduled Procedure No. 2: N/A
 Scheduled Procedure No. 3: N/A
 Procedure Date: N/A
 Procedure Code: N/A

PATIENT INFORMATION

First Name	Last Name	MRN	Age	Sex	DOB	SSN	Work	Home	Cell	Emergency	Insurance
Patricia	Newman	1668007	61	Female	08-03-1946						

Marital Status: Divorced Ethnic Background: Caucasian Religion: Christian

User: Demo User (demo) | Scenario 1 | Simulation Day/Time: Tue at 16:30 | Elsevier. All rights reserved.

CONSENTS

Consent forms for blood transfusions and other diagnostic or surgical procedures are provided in the **Consents** tab. Consents cannot be modified by the student in this section, but some scenarios require a blank consent form to be printed out by the facilitator and provided as a prop during the scenario; in these cases, the form is available from the Preparing the Setting screen, or within the **Facilitator's Packet**. Learning activities related to consents may include discussions related to the legal implications of obtaining consents.

Surgical Consent - Page 1

Inform Consent for Surgical and Diagnostic Procedures

Name: Lillian Chambers MRN: 7781324
 Age: 40 Room: 437
 Sex: Female
 Physician: Rhonda Spratt, MD

- I acknowledge and understand that the following procedure(s) that has been described in general terms is to be performed on me:
Open appendectomy
- I understand that my condition has been diagnosed as:
Acute appendicitis with rupture
- I understand that the purpose of this procedure is:
To remove appendix and treat the infection
- I understand that the practice of medicine is not an exact science and that, consequently, all medical procedures carry some risk. I understand that the procedure(s) described above may carry a material risk of infection, allergic reaction, disfiguring scar, severe loss of blood, loss of function of any limb or organ, paralysis or partial
- I understand that if I do not undergo this proposed procedure, my prognosis is:
Potentially fatal
- I understand that the practical alternatives to this procedure recognized and accepted by reasonable physicians include:
None
- I authorize the hospital to dispose of any severed tissue, organs, or body parts in accordance with the law and hospital policies.
- I also consent to diagnostic studies, tests, anesthesia, x-ray examinations, and any other treatment or course of treatment relating to the diagnosis or procedures

Surgical Consent - Page 1 Close

User: Danny Witofsky (witofsky) | Scenario 8 | Sim Day/Time: Thu at 16:00 | Elsevier. All rights reserved.

SIGNATURES

This page is simply the electronic signature page for health care providers who have previously recorded data on the medical record.

Simulation Learning System

MRN: 1668007 Room: 406 Age: 61 Physician: Joseph Molina, MD
 Patient: Patricia Newman Gender: Female Weight: 100 lb Allergies: [None] Code Status: Full Code

Signatures

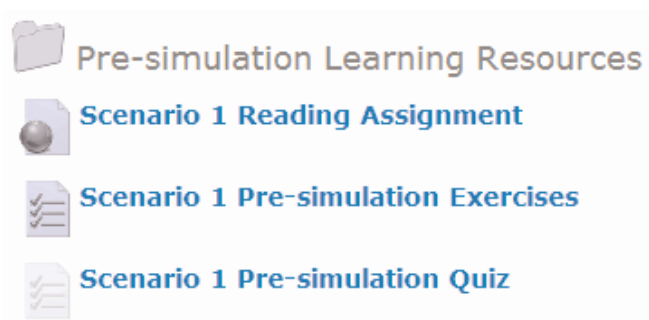
INITIALS	NAME
JM	Joseph Molina, MD
TH	Toby Miller, MD
RM	Miranda Martinez, MD
HA	Haggie Austin, RN
BF	Billy Fuego, RN
SH	Susan Hunter, RN
DW	Danny Witofsky

User: Danny Witofsky (witofsky) | Scenario Newman 1 | Sim Day/Time: Tue at 16:30 | Elsevier. All rights reserved.

Using Student, Faculty, and Evolve Resources

PRE-SIMULATION LEARNING RESOURCES

While you are preparing the scenario and the environment, students also need preparation in order to maximize their time in simulation. You may elect to have students do all, some, or none of the pre-simulation assignments. Students who complete these assignments independently can submit their responses electronically to the facilitator.



Reading Assignments offer relevant content in your nursing text that will help students prepare for the scenario. These textbook readings correlate specifically with the learning outcomes for each simulation scenario. Before the simulation experience, the facilitator may assign general readings so that students can prepare adequately for the events that may occur in the simulation scenario, without revealing the specific storyline of the scenario. Students who are adequately prepared for the simulation scenarios can use this foundational knowledge and build on it during the scenario, thus honing their critical thinking abilities. The reading assignment may also serve as a guide for students as they complete the pre- and post-simulation exercises and quizzes.

Concept Mapping. Using the **Concept Map Creator** designed to accompany the specific nursing textbook, students can create a concept map linking the patient's medical diagnoses, clinical manifestations, collaborative problems, pathophysiology, risk factors, nursing diagnoses, interventions, and expected outcomes. The concept map can be saved as a final draft, saved for future modification, or printed.





Pre-simulation Exercises are meant to encourage higher level thinking in the nursing student and should be completed before the simulation experience. The exercises reinforce concepts related to the nursing process, pathophysiology, patient education, and other issues that may be pertinent to the elements of the scenario, without revealing the specifics related to the scenario. These exercises can be performed independently or in a group setting led by a facilitator. Once completed, the student can submit the answers to the facilitator. These pre-simulation exercises should be discussed during the debriefing session following the simulation.

The **Pre-simulation Quiz** contains 6 to 10 multiple choice questions that allow students to evaluate their knowledge and understanding of the reading assignment prior to simulation. Once students submit their answers, the quiz is automatically graded and rationales are provided for the correct and incorrect answers, along with textbook page references. The quiz grades can be automatically entered into the instructor's gradebook.

POST-SIMULATION LEARNING RESOURCES

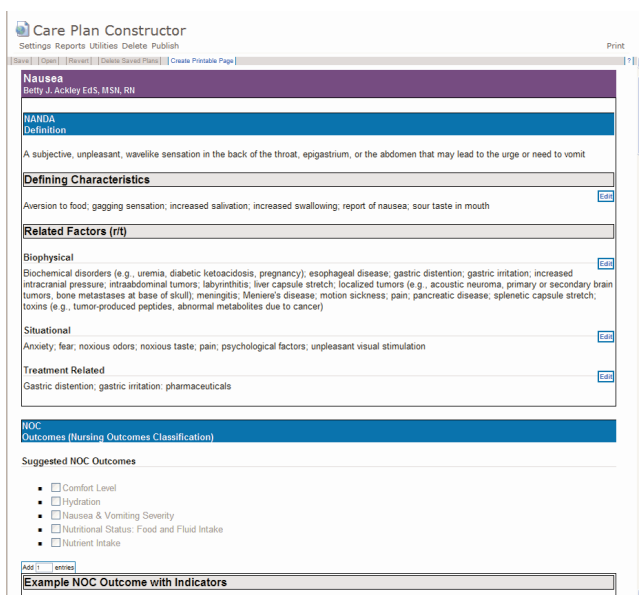
Following the debriefing session, the facilitator may wish to assign post-simulation activities. These activities are designed to summarize the important elements of each scenario, reinforce relevant concepts, promote student self-reflection, and encourage retention and understanding of the nursing care related to the scenario. Post-simulation assignments can be performed independently or in a group setting led by a facilitator. Students who complete these assignments online can submit their responses electronically to the facilitator for grading and feedback.

Post-simulation Learning Resources

-  **Scenario 1 Journaling**
Reflect on your simulation experience.
-  **Scenario 1 Interdisciplinary Communication**
Using the SBAR method, provide a change-of-shift report for the oncoming nurse.
-  **Scenario 1 Post-simulation Exercises**
-  **Scenario 1 Post-simulation Quiz**

Documentation (EMR). Documenting patient care is a fundamental nursing skill. Before, during, and after the simulation event, the student can practice referencing and documenting care in the **EMR**. When students document in the **EMR** under their specific login, the data is saved only to that particular student account. When logged into the **EMR**, students have the option to save data and return to the patient chart to complete documentation at a later time, or to submit the chart electronically to the facilitator for review.

A **Care Plan Constructor** guides the student in the creation of a care plan that they can customize for the patient. The **Care Plan Constructor** allows the student to identify nursing diagnoses using NANDA, NOC, or NIC format, and outline evidence-based nursing interventions appropriate for the patient. The student may then save or print out the customized care plan.



The screenshot shows the 'Care Plan Constructor' interface. At the top, it says 'Nausea' and 'Betty J. Ackley EdS, MSN, RN'. Below this is the 'NANDA Definition' section, which states: 'A subjective, unpleasant, wavelike sensation in the back of the throat, epigastrium, or the abdomen that may lead to the urge or need to vomit'. The 'Defining Characteristics' section lists: 'Aversion to food; gagging sensation; increased salivation; increased swallowing; report of nausea; sour taste in mouth'. The 'Related Factors (rit)' section lists: 'Biochemical disorders (e.g., uremia, diabetic ketoacidosis, pregnancy); esophageal disease; gastric distention; gastric irritation; increased intracranial pressure; intraabdominal tumors; labyrinthitis; liver capsule stretch; localized tumors (e.g., acoustic neuroma, primary or secondary brain tumors, bone metastases at base of skull); meningitis; Meniere's disease; motion sickness; pain; pancreatic disease; splenic capsule stretch; toxins (e.g., tumor-produced peptides, abnormal metabolites due to cancer)'. The 'Situational' section lists: 'Anxiety; fear; noxious odors; noxious taste; pain; psychological factors; unpleasant visual stimulation'. The 'Treatment Related' section lists: 'Gastric distention; gastric irritation; pharmaceuticals'. Below this is the 'NOC Outcomes (Nursing Outcomes Classification)' section, which lists 'Suggested NOC Outcomes': 'Comfort Level', 'Hydration', 'Nausea & Vomiting Severity', and 'Nutritional Status: Food and Fluid Intake'. At the bottom, there is an 'Add' button and a section titled 'Example NOC Outcome with Indicators'.

Journaling. After the simulation event, students can be encouraged to practice self-reflection by completing a journaling assignment. If desired, the journal question can be modified by the facilitator to reflect a particular style, such as the journal format used during student clinical rotations. After the student completes the journal entry, it can be submitted electronically to the facilitator for evaluation or grading.

Interdisciplinary Communication. SBAR (situation, background, assessment, and recommendation) communication should be expected in all verbal reports during simulation. The SBAR post-simulation **Interdisciplinary Communication** activity gives students the opportunity to practice SBAR in a written format. In this activity, students are instructed to provide an SBAR change-of-shift report for the nurse assuming care for the simulated patient after the scenario is over. The SBAR report can be submitted electronically to the facilitator for evaluation or grading.

Post-simulation Exercises activities extend the simulation experience beyond the lab, promoting further critical thinking and clinical judgment related to events encountered during the scenario. As with the pre-simulation exercises, answers are provided, but because the exercises are short answer, they are not self-grading. Once completed, the student can submit the answers electronically to the facilitator for grading.

The *Post-simulation Quiz* focuses on key scenario events and can assist the facilitator in identifying students' areas of understanding and areas needing additional review and practice. The quiz is self-grading and provides immediate feedback to students with rationales and page references to their nursing textbook.

ACTIVATING AND DEACTIVATING STUDENT RESOURCES

The SLS pre-simulation and post-simulation student resources described above are designed to enhance understanding and have a positive impact on learning outcomes. All of these resources can be made available or unavailable to students at your discretion. You should review and activate or deactivate the appropriate resources depending on your students' knowledge base and level of experience with simulation:

1. Navigate to the course folder containing the resource you wish to make available.



2. Select **Settings** from the menu that appears under the resource title.



3. Select the **Access** tab. From this section, the *Evolve Learning System* allows you to restrict access by individual student.

RN-to-RN Patient Report

Settings: ☒ Normal ☐ Advanced

Content **Access** Standards Automate Assignment

Access Tracking

User Tracking Disabled

View Restrictions

☐ Do not allow users to view this item

User Access Role/Team Access

Viewable By Students

Password

Team Access All Teams

Save Cancel

4. Under View Restrictions, select **Individual/User Access** from the User Access drop-down menu. (If you wish to restrict access by using teams, leave this selection as **Role/Team Access**.)

RN-to-RN Patient Report

Settings: ☒ Normal ☐ Advanced

Content **Access** Standards Automate Assignment

Access Tracking

User Tracking Disabled

View Restrictions

☐ Do not allow users to view this item

User Access Role/Team Access
Role/Team Access
Individual/User Access


Viewable By Students

Password

Team Access All Teams

Save Cancel

5. A list of currently enrolled students will appear in the User Access List. Check the box next to each student's name to make that resource available. Un-check the box to deny access.

 RN-to-RN Patient Report

Settings: ☒ Normal ☐ Advanced

Content **Access** Standards Automate Assignment

Access Tracking

User Tracking Disabled

View Restrictions

☐ Do not allow users to view this item

User Access Individual/User Access

User Access List

Check All Uncheck All

There are currently 6 enrolled users.

Allow	Name	Username	Rights	Title	Teams
<input checked="" type="checkbox"/>	Gibson, June	jgibson	Students	Student	
<input checked="" type="checkbox"/>	Markman, John	jmarkman	Students	Student	
<input checked="" type="checkbox"/>	Mason, Cheryl	cmason	Students	Student	
<input type="checkbox"/>	Oliver, Mark	cmason	Students	Student	
<input checked="" type="checkbox"/>	Pearson, Bonnie	bpearson	Students	Student	
<input type="checkbox"/>	Reynolds, Jennifer	jreynolds	Students	Student	

Password

Save Cancel

6. Additionally, you may restrict access to a resource by assigning a password in the Access settings. Be sure to communicate this password to students so that they will be able to access the resource.
7. Click **Save**.

GRADEBOOK

Evaluation of students' work throughout the SLS is managed using the gradebook of the *Evolve Learning Management System*. You may access the gradebook from the menu under the Group Management section of the Course Toolbox:

The screenshot shows the Course Toolbox interface. On the left, there are three expandable sections: 'Group Settings', 'Data Management', and 'Group Management'. The 'Group Management' section is expanded, showing a list of options: 'Gradebook', 'Roster', 'Teams', and 'Attendance'. The 'Data Management' section is also visible, showing options like 'Repository Files Manager', 'Backup/Restore', 'Import Wizard', 'Export Wizard', and 'Data Maintenance'.

You will be presented with the Evolve gradebook setup wizard when you first access your gradebook. You may use this tool to customize the assignments and gradebook to suit your needs. Detailed instructions for configuring your gradebook are included in the Manage tab of the *Evolve Learning System User's Manual*, which is also contained within the Tools menu.

Gradebook Setup - Step 1

TIP : [Click Here](#) to learn more about the gradebook setup wizard and other commonly used features.

Gradebook Mode:

- ☒ **Points**
This option enables simple points-based grading. Formulas are available at the assignment level only.
- ☐ **Percentage**
This option enables percentage-based grading. Category weighting and formulas are available.

Title	Calculation
Homework	Use all assignments ▼
Quizzes	Use all assignments ▼
Exams	Use all assignments ▼
	Use all assignments ▼
	Use all assignments ▼
	Use all assignments ▼
	Use all assignments ▼

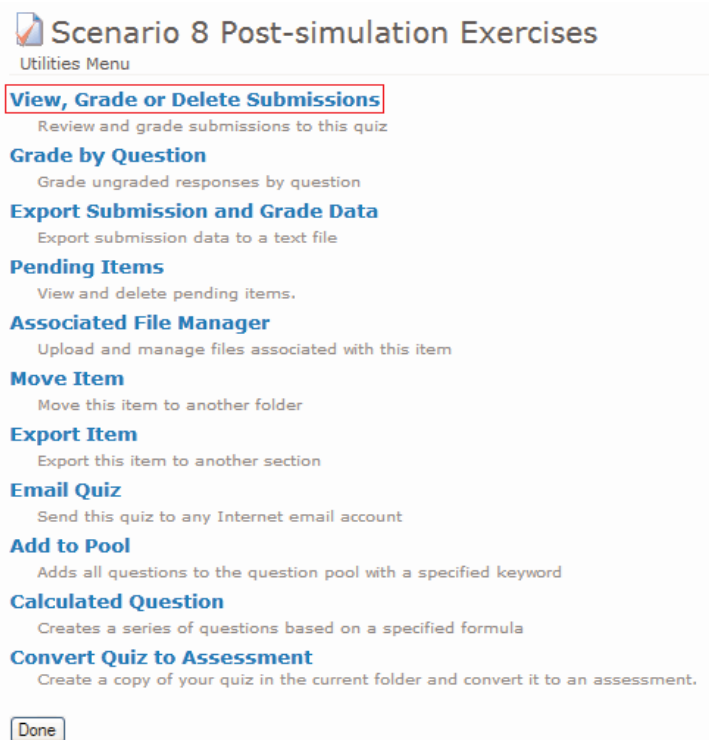
GRADING ASSIGNMENTS

The SLS pre- and post-simulation quizzes are graded automatically by the *Evolve Learning Management System*. All remaining assignments (e.g., exercises, essay questions, concept mapping, EMR documentation) must be manually evaluated and graded by you:


1. View the activity you wish to grade within the Simulation Scenarios directory.
2. Select 'Utilities' from the menu beneath the title of the activity.



3. Select 'View, Grade, or Delete Submissions' from the list of utilities.




4. You will be presented with a list of submissions from all students. Click 'Grade' next to the student's User ID to view and submit a score for that student's response.

 **Scenario 8 Post-simulation Exercises**
Utilities > Submissions

			<u>User ID</u>	<u>Grade (100 pts)</u>	<u>Submitted</u>	<u>IP Address</u>
View	Grade	Delete	Newton, Chelsea (cnewton)		6/2/2010 4:50:45 PM	198.185.18.72
View	Grade	Delete	Newton, Chelsea (cnewton)		6/2/2010 4:08:21 PM	198.185.18.72
View	Grade	Delete	Korte, Jennifer (jkorte01)		5/30/2010 8:14:41 PM	66.90.11.100
View	Grade	Delete	de Sousa, Marc (mdesousa)		5/21/2010 1:07:56 PM	70.141.63.190

[Done](#)

5. After reviewing the response, enter the points you wish to award in the Score field.

 **Scenario 8 Post-simulation Exercises**
Utilities > Submissions > Grade submission by Newton, Chelsea (cnewton) on 6/2/2010 4:50:45 PM

☐ Hide Graded Items


Points Awarded	0
Points Missed	0
Points Ungraded	30

1. Discuss the probable cause of the auscultation of crackles in Maurice Arviso's lungs.

Score Feedback

Max: 10

[HTML Editor](#)

 **Points** ?/10, This item will be graded later.

Earned:

Correct Crackles are typically heard during inspiration and cannot usually be cleared with coughing.

Answer: As with Mr. Arviso, crackles occur most frequently in the bases of the lungs. Mr. Arviso's pneumonia is most likely contributing to the auscultated crackles. Crackles may be caused by the sudden re-inflation of alveoli that have collapsed due to the pneumonia or disruption of the passage of air through the small airways caused by the pneumonia.

Your Response:

6. Click **OK** after you have graded all responses. You may return to an activity and assign or revise grades at any time.
7. Return to the Assignment window to continue grading other assignments. Click **Done** when finished. You may also grade individual assignments within the Pre- and Post-simulation Learning Resources folder of each scenario. Simply select Utilities from the menu beneath each activity.

GRADING STUDENT DOCUMENTATION IN THE EMR

The process for grading EMR submissions is the same as grading other activity submissions. However, if a student has submitted a scenario's EMR more than once, remember to grade only the most recent submission.

SLS Observer Evaluation Rubric

Observe the simulation scenario and assess the participants' management of the situation. Note areas in which participants performed well and areas in which they need improvement. Use these observations to provide feedback and participate in discussion during debriefing.

NCLEX® Client Needs Category	Exemplars observed during scenario:	Opportunities for improvement:
1. SAFE AND EFFECTIVE CARE ENVIRONMENT: MANAGEMENT OF CARE		
2. SAFE AND EFFECTIVE CARE ENVIRONMENT: SAFETY AND INFECTION CONTROL		
3. HEALTH PROMOTION AND MAINTENANCE		
4. PSYCHOSOCIAL INTEGRITY		

Observer Evaluation Rubric—cont'd

NCLEX® Client Needs Category	Exemplars observed during scenario:	Opportunities for improvement:
5. PHYSIOLOGICAL INTEGRITY: BASIC CARE AND COMFORT		
6. PHYSIOLOGICAL INTEGRITY: PHARMACOLOGICAL AND PARENTERAL THERAPIES		
7. PHYSIOLOGICAL INTEGRITY: REDUCTION OF RISK POTENTIAL		
8. PHYSIOLOGICAL INTEGRITY: PHYSIOLOGICAL ADAPTATION		

Observer Evaluation Rubric—cont'd

1. SAFE AND EFFECTIVE CARE ENVIRONMENT: MANAGEMENT OF CARE

- **NCLEX® CATEGORY: SAFE AND EFFECTIVE CARE ENVIRONMENT**—The nurse promotes the achievement of patient outcomes by providing and directing nursing care that enhances the care delivery setting in order to protect patients, family/significant others, and health care personnel.
- **NCLEX® SUBCATEGORY: MANAGEMENT OF CARE**—Providing and directing nursing care that enhances the care delivery setting to protect patients, family/significant others, and health care personnel.

Related content includes but is not limited to:

- | | |
|---|--|
| <ul style="list-style-type: none"> • Advance Directives • Delegation • Advocacy • Establishing Priorities • Case Management • Ethical Practice • Patient Rights • Informed Consent • Collaboration with Interdisciplinary Team | <ul style="list-style-type: none"> • Information Technology • Concepts of Management • Legal Rights and Responsibilities • Confidentiality/Information Security • Performance Improvement (Quality Improvement) • Consultation • Referrals • Continuity of Care • Supervision |
|---|--|

Related QSEN Competencies:

- **Patient-Centered Care:** Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.
- **Teamwork and Collaboration:** Function effectively within nursing and interprofessional teams, fostering open communication, mutual respect, and shared decision-making to achieve quality patient care.
- **Safety:** Minimize risk of harm to patients and providers through both system effectiveness and individual performance.
- **Quality Improvement:** Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems.
- **Informatics:** Use information and technology to communicate, manage knowledge, mitigate error, and support decision making.

Related 2010 National Patient Safety Goals:

- **Goal 2:** Improve the effectiveness of communication among caregivers.
- **Goal 13:** Encourage patients' active involvement in their own care as a patient safety strategy.

Observer Evaluation Rubric—cont'd

2. SAFE AND EFFECTIVE CARE ENVIRONMENT: SAFETY AND INFECTION CONTROL

- **NCLEX® CATEGORY: SAFE AND EFFECTIVE CARE ENVIRONMENT**—The nurse promotes the achievement of patient outcomes by providing and directing nursing care that enhances the care delivery setting in order to protect patients, family/significant others, and health care personnel.
- **NCLEX® SUBCATEGORY: SAFETY AND INFECTION CONTROL**—Protecting patients, family/significant others, and health care personnel from health and environmental hazards.

Related content includes but is not limited to:

- | | |
|---|--|
| • Accident/Injury Prevention | • Security Plan |
| • Emergency Response Plan | • Handling Hazardous and Infectious Materials |
| • Reporting of Incident/Event/Irregular Occurrence/Variance | • Standard Precautions/Transmission-Based Precautions/Surgical Asepsis |
| • Ergonomic Principles | • Home Safety |
| • Safe Use of Equipment | • Use of Restraints/Safety Devices |
| • Error Prevention | |

Related QSEN Competencies:

- **Safety:** Minimize risk of harm to patients and providers through both system effectiveness and individual performance.
- **Quality Improvement:** Use data to monitor the outcomes of care processes and use improvement methods to design and test changes to continuously improve the quality and safety of health care systems.

Related 2010 National Patient Safety Goals:

- **Goal 1:** Improve the accuracy of patient identification.
- **Goal 3:** Improve the safety of using medications.
- **Goal 7:** Reduce the risk of health care associated infections.
- **Goal 9:** Reduce the risk of patient harm resulting from falls.
- **Goal 13:** Encourage patients' active involvement in their own care as a patient safety strategy.
- **Goal 15:** Identify safety risk inherent in patient population.

Observer Evaluation Rubric—cont'd

3. HEALTH PROMOTION AND MAINTENANCE

- **NCLEX® CATEGORY: HEALTH PROMOTION AND MAINTENANCE**—The nurse provides and directs nursing care of the patient and family/significant others that incorporates the knowledge of expected growth and development principles; prevention and/or early detection of health problems, and strategies to achieve optimal health.

Related content includes but is not limited to:

- Aging Process
- High Risk Behaviors
- Ante/Intra/Postpartum and Newborn Care
- Lifestyle Choices
- Developmental Stages and Transitions
- Principles of Teaching/Learning
- Health and Wellness
- Self-Care
- Health Promotion/Disease Prevention
- Techniques of Physical Assessment
- Health Screening

Related QSEN Competencies:

- **Patient-Centered Care:** Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.
- **Evidence-Based Practice:** Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.

Related 2010 National Patient Safety Goals:

- **Goal 10:** Reduce the risk of influenza and pneumococcal disease in institutionalized older adults.
- **Goal 13:** Encourage patients' active involvement in their own care as a patient safety strategy.

Observer Evaluation Rubric—cont'd

4. PSYCHOSOCIAL INTEGRITY

- **NCLEX® CATEGORY: PSYCHOSOCIAL INTEGRITY**—The nurse provides and directs nursing care that promotes and supports the emotional, mental, and social wellbeing of the patient and family/significant others experiencing stressful events, as well as patients with acute or chronic mental illness.

Related content includes but is not limited to:

- Abuse/Neglect
- Grief and Loss
- Behavioral Interventions
- Mental Health Concepts
- Chemical and Other Dependencies
- Religious and Spiritual Influences on Health
- Coping Mechanisms
- Sensory/Perceptual Alterations
- Crisis Intervention
- Stress Management
- Cultural Diversity
- Support Systems
- End-of-Life Care
- Therapeutic Communication
- Family Dynamics
- Therapeutic Environment

Related QSEN Competencies:

- **Patient-Centered Care:** Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.
- **Evidence-Based Practice:** Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.

Related 2010 National Patient Safety Goals:

- **Goal 13:** Encourage patients' active involvement in their own care as a patient safety strategy.
- **Goal 15:** Identify safety risk inherent in patient population.

Observer Evaluation Rubric—cont'd

5. **PHYSIOLOGICAL INTEGRITY: BASIC CARE AND COMFORT**

- **NCLEX® CATEGORY: PHYSIOLOGICAL INTEGRITY**—The nurse promotes physical health and wellness by providing care and comfort, reducing patient risk potential, and managing health alterations.
- **NCLEX® SUBCATEGORY: BASIC CARE AND COMFORT**—Providing comfort and assistance in the performance of activities of daily living.

Related content includes but is not limited to:

- Assistive Devices
- Nutrition and Oral Hydration
- Elimination
- Personal Hygiene
- Mobility/Immobility
- Rest and Sleep
- Non-Pharmacological Comfort Interventions

Related QSEN Competencies:

- **Patient-Centered Care:** Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.
- **Evidence-Based Practice:** Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.

Related 2010 National Patient Safety Goals:

- **Goal 9:** Reduce the risk of patient harm resulting from falls.
- **Goal 13:** Encourage patients' active involvement in their own care as a patient safety strategy.
- **Goal 14:** Prevent health care associated pressure ulcers.

Observer Evaluation Rubric—cont'd

6. **PHYSIOLOGICAL INTEGRITY: PHARMACOLOGICAL AND PARENTERAL THERAPIES**

- **NCLEX® CATEGORY: PHYSIOLOGICAL INTEGRITY**—The nurse promotes physical health and wellness by providing care and comfort, reducing patient risk potential, and managing health alterations.
- **NCLEX® SUBCATEGORY: PHARMACOLOGICAL AND PARENTERAL THERAPIES**—Providing care related to the administration of medications and parenteral therapies.

Related content includes but is not limited to:

- Adverse Effects/Contraindications/Side Effects/Interactions
- Expected Actions/Outcomes
- Medication Administration
- Blood and Blood Products
- Parenteral/Intravenous Therapies
- Central Venous Access Devices
- Pharmacological Pain Management
- Dosage Calculation
- Total Parenteral Nutrition

Related QSEN Competencies:

- **Evidence-Based Practice:** Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.
- **Safety:** Minimize risk of harm to patients and providers through both system effectiveness and individual performance.

Related 2010 National Patient Safety Goals:

- **Goal 1:** Improve the accuracy of patient identification.
- **Goal 3:** Improve the safety of using medications.
- **Goal 8:** Accurately and completely reconcile medications across the continuum of care.

Observer Evaluation Rubric—cont'd

7. **PHYSIOLOGICAL INTEGRITY: REDUCTION OF RISK POTENTIAL**

- **NCLEX® CATEGORY: PHYSIOLOGICAL INTEGRITY**—The nurse promotes physical health and wellness by providing care and comfort, reducing patient risk potential, and managing health alterations.
- **NCLEX® SUBCATEGORY: REDUCTION OF RISK POTENTIAL**—Reducing the likelihood that patients will develop complications or health problems related to existing conditions, treatments, or procedures.

Related content includes but is not limited to:

- Changes/Abnormalities in Vital Signs
- Diagnostic Tests
- Potential for Complications from Surgical Procedures and Health Alterations
- Laboratory Values
- System Specific Assessments
- Potential for Alterations in Body Systems
- Therapeutic Procedures
- Potential for Complications of Diagnostic Tests/Treatments/Procedures

Related QSEN Competencies:

- **Evidence-Based Practice:** Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.
- **Safety:** Minimize risk of harm to patients and providers through both system effectiveness and individual performance.

Related 2010 National Patient Safety Goals:

- **Goal 7:** Reduce the risk of health care associated infections.
- **Goal 9:** Reduce the risk of patient harm resulting from falls.
- **Goal 10:** Reduce the risk of influenza and pneumococcal disease in institutionalized older adults.
- **Goal 11:** Reduce the risk of surgical fires.
- **Goal 15:** Identify safety risk inherent in patient population.
- **Goal 16:** Improve recognition and response to changes in a patient's condition.

Observer Evaluation Rubric—cont'd

8. **PHYSIOLOGICAL INTEGRITY: PHYSIOLOGICAL ADAPTATION**

- **NCLEX® CATEGORY: PHYSIOLOGICAL INTEGRITY**—The nurse promotes physical health and wellness by providing care and comfort, reducing patient risk potential, and managing health alterations.
- **NCLEX® SUBCATEGORY: PHYSIOLOGICAL ADAPTATION**—Managing and providing care for patients with acute, chronic, or life threatening physical health conditions.

Related content includes but is not limited to:

- Alterations in Body Systems
- Medical Emergencies
- Fluid and Electrolyte Imbalances
- Pathophysiology
- Hemodynamics
- Unexpected Response to Therapies
- Illness Management

Related QSEN Competencies:

- **Patient-Centered Care:** Recognize the patient or designee as the source of control and full partner in providing compassionate and coordinated care based on respect for patient's preferences, values, and needs.
- **Evidence-Based Practice:** Integrate best current evidence with clinical expertise and patient/family preferences and values for delivery of optimal health care.

Related 2010 National Patient Safety Goals:

- **Goal 13:** Encourage patients' active involvement in their own care as a patient safety strategy.
- **Goal 16:** Improve recognition and response to changes in a patient's condition.

References

- The Joint Commission. (2010). *National Patient Safety Goals*. Retrieved June 28, 2010, from <http://www.jointcommission.org/patientsafety/nationalpatientsafetygoals/>
- National Council of State Boards of Nursing. (2010). *NCLEX-RN Test Plan*. Retrieved June 28, 2010, from https://www.ncsbn.org/2010_NCLEX_RN_TestPlan.pdf
- Quality and Safety Education for Nurses. (2010). *Quality and Safety Competencies*. Retrieved June 28, 2010, from <http://www.qsen.org/competencies.php>